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AUTHOR Luehr, Ruth Ellen; Hoxie, Ann
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ABSTRACT

The goal of Minnesota's Early Childhood Screening (ECS) program is to identify normal aspects of a child's health and development while sorting out potential problems that need further evaluation. In addition, all parents are linked to resources in the school and community to enhance their child's development and their own parenting skills. This handbook describes the requirements of the ECS programs; delineates activities required in program planning, delivery, evaluation, and reporting; specifies standards and preferred practice for screening and referral; and describes the concepts and principles that are the basis for ECS. Chapter 1, "Early Childhood Screening Program," describes ECS and the Child and Teen Checkup programs. Chapter 2, "ECS Program Administration," discusses annual planning and annual summary reports. Chapter 3, "ECS Program Implementation: Checklist for ECS Program," details the program requirements and steps for program implementation. Included are coordination/planning; evaluating, screening implementation, including outreach, screening, and follow-up; and data, records, and reporting. Chapter 4, "Introduction to Concepts Core to ECS," describes seven conceptual frameworks underlying the design of ECS, supporting its implementation, and guiding local and state evaluation efforts. The seven frameworks are: (1) prevention concepts; (2) screening principles; (3) development theory; (4) family factors; (5) health promotion; (6) problem solving; and (7) collaboration concepts. Eight appendices include Minnesota ECS and related education statutes and rules; implementation guidelines and tools; media resources; screening forms; pupil health information; annual report forms and instructions; contacts for Minnesota Early Childhood Screening Program, 1995; and a statewide summary. (KDFB)

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1995

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Early Childhood Screening

Program Administration Manual

APRIL 1995

Minnesota Department of Education
Office of Service Design and Collaboration
550 Cedar Street
St. Paul, Minnesota 55101

MDE
MINNESOTA DEPARTMENT OF EDUCATION

Authors

Ruth Ellen Luehr
MDE Early Childhood Screening Specialist
1981 - 1987, 1991 - 1994

Ann Hoxie
MDE Early Childhood Screening Consultant
St. Paul Public Schools
Spring - Summer, 1994

Reviewers/Editors

Mary Jo Hofer
Coordinator of Early Childhood Programs
Freshwater Education District (Staples Area)

Maria Rubin
Nursing Consultant
Minnesota Department of Health

Sara Schoepf
Regional Interagency System Change (RISC) Coordinator
ECSU 5, Staples, Minnesota

Wendy Walz
Coordinator of Early Childhood Programs
Litchfield Public Schools, Minnesota

Linda Weber
School Nurse
St. Paul Public Schools, Minnesota

Lois Engstrom
Team Leader
MDE Community and Family Education

Debbykay Peterson
MDE Early Childhood Screening/Learning Readiness Specialist

Format

Susan Martinek
MDE Community & Family Education, Desktop Publisher

INTRODUCTION

Early Childhood Screening (ECS) was established by the Legislature in 1977. The goal of ECS is to identify normal aspects of a child's health and development while sorting out potential problems that need further evaluation. In addition, parents are supported for the positive ways their children are growing and developing. All parents are linked to resources in the school and community to enhance their child's development and their own parenting skills.

This handbook:

1. Describes the requirements of the ECS programs according to the law and rule.

2. Delineates activities required in program planning, delivery, evaluation, and reporting.

3. Specifies standards and preferred practice for screening and referral.

4. Describes the concepts and principles that are the basis for ECS.

Chapter I includes a **description of Early Childhood Screening** in capsule form and also in a longer overview format. The other Minnesota screening programs, namely the Child and Teen Checkups programs, are described. A **chart comparing the Minnesota screening programs** is included.

Chapter II discusses two administrative tasks - **annual planning** and the **annual summary reports**.

Chapter III describes in detail the **program requirements** and **steps for program implementation**. The chapter refers to the **Checklist for ECS Program** (Appendix B) and follows the format of the checklist: **Coordinating/Planning, Evaluating, Screening Implementation, and Data, Records and Reporting**. The current Checklist is in Appendix B; it is changed annually by MDE to reflect any legislative or policy changes in ECS. Another useful tool in the chapter is the **ECS PER (Planning, Evaluating, Reporting) Tool**. This is designed for use by ECS Coordinators with their screening staff and community referral resources both in designing the program and in evaluating the program. The chapter continues with an **explanation of the three stages of the screening program - outreach, screening, and follow-up**. The chapter also includes charts with **detailed information on the screening components, standards for screening personnel**, and notes on **where to access the documents** that outline the standards for screening and referral for each component. Forms for each component are also included in this section..

Chapter IV briefly describes **seven theories** or conceptual frameworks that are the basis for the design of Early Childhood Screening. These concepts support the implementation of the program and guide evaluation efforts at the local and state levels.

The *appendices* contain essential documents, most of which are subject to change annually. For the convenience of ECS Coordinators, these are put in the appendix so they can be pulled and replaced with the new versions on a yearly basis.

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I. EARLY CHILDHOOD SCREENING

A. ECS - A CAPSULE

Through Early Childhood Screening (ECS) educators and health professionals focus on a child's health and development. All families are linked to school and community programs that promote health and enhance a child's well being. Using a series of standardized screening instruments and structured interview procedures, screeners identify the normal aspects of health and development of a child while sorting out conditions and situations that require further assessment. Children and families needing further assessment are referred to a variety of school and community services. Then ECS providers follow-up by contacting parents to ensure that referral sources are accessible, acceptable, and the identified needs have been met and/or the child and family are in an ongoing system of service and support.

Minnesota school districts are required to offer the screening to children once before school entrance, targeting children ages 3½ to 4 years old. In 1992 **participation in screening became a requirement for children prior to school enrollment**. Approximately 62,000 children statewide participate in screening each school year.

Purposes: •Assist parents and communities to improve the educational readiness and health of young children through early detection of health, developmental, and risk factors that may interfere with a child's learning and on-going development.

•Assist schools and their communities in planning education and health programs for all children and families, focussing on those at risk.

•Link families to learning readiness initiatives in the school and community.

Objectives:• Detect conditions that may interfere with young children's growth, development, and learning by predicting and preventing problems, minimizing physical and educational barriers, and aiding in dealing with special needs of individual children, thereby reducing later costly care.

•Enable parents to become more aware of the connections among physical health, development, and readiness for learning. In addition to the connections between family circumstances and a child's development and learning.

•Link children and families to a wide range of community services and programs to enhance their development and readiness for formal education. This includes collaboration with other early childhood programs such as Early Childhood Family Education, Learning Readiness, Early Childhood Special Education, and Head Start.

•Improve access to and regular use of preventive health services by increasing awareness of the need for early and periodic health services, discussing financing of health care with parents including enrollment in MinnesotaCare if pertinent, and linking families to public/ private health care providers.

Schools work in collaboration with other early childhood programs and public or private health care providers to offer a comprehensive and cost effective program. **Outreach** is an intensive effort to notify all parents of the requirement for screening, of their options for services, and to encourage participation early at ages 3½ - 4. The actual **screening** is staffed by personnel from preK-12 education, early childhood special education, special education, early childhood family education, community education, and/or contracts with community health agencies and education cooperatives. **Follow-up** includes guaranteeing that problems noted have been assessed, resolved, or the family is linked with ongoing services and support.

The state reimburses school districts for planning, administering, and evaluating the program. The present state reimbursement rate is $25 per child screened.

(From the Fiscal Year 96 (1995-96) - Fiscal Year 97 (1996-97) Biennial Budget submitted by the Minnesota Department of Education to the Governor and the Legislature in January 1995.)

B. OVERVIEW OF THE ECS PROGRAM

ECS Program Requirements

Each local school board is required to provide an Early Childhood Screening program for children once before school entrance, targeting children who are between 3½ and 4 years old. Children are required to participate in a screening program prior to school entrance (or within 30 days of enrollment) at the kindergarten level. Children may participate in the school district Early Childhood Screening (ECS) program or he/she may receive services from a comparable program offered by a private or public health provider. If a statement signed by the child's parent or guardian is submitted to the school administrator stating that the child has not been screened because of conscientiously held beliefs of the parent or guardian, the screening is not required. The requirements for the Early Childhood Screening program are found in state statute, MS 123.701-123.7045, and state rule, MR 3530.3000-3530.4310 (see Appendix A for the statute and rule). The Checklist for ECS Program (see Appendix B) lists the program requirements in a planning and implementation model, and includes these sections: Coordinating/Planning, Evaluating, Outreach/Notifying Parents, Screening Components, Referral and Follow-up, and Data/Records.

ECS Program Focus

ECS is based on the concept that a screening program can detect potential health problems and deviations of growth and development. The program is not a substitute for on-going family health care. If a child's screening indicates a condition which requires further evaluation, the parent is notified of the condition. Referrals for health and/or educational evaluation and treatment are made. An appropriate follow-up process is available to ensure proper evaluation of the suspected problem, the referral resources are accessible and acceptable to the parents, and that the problems are remediated or the child is receiving ongoing care and service.

ECS seeks to promote the growth, well being, and health of Minnesota children. In recent years ECS has evolved into a process that, in addition to screening for health and

developmental concerns, includes a review of risk factors that might affect the child's learning and development. Such factors may include, but are not limited to, access to health care, a history of health problems or risks in current health status, family resources and needs, and child care and early childhood experiences. ECS programs then refer children and families to programs and services that support the child's health, development, and readiness to learn.

Data collected on children and families through ECS are private, and no detailed data in components such as the health history, family factors, or parent report of the child's development are disclosed to a third party (including the school district) without parental consent. A summary of the screening findings by component is required for school enrollment, but only with parental consent can more extensive information on individual children be incorporated into school district records. All information from the screening is to be available to parents.

Each local school district annually plans the ECS program according to the set criteria. School boards may establish the program individually, in cooperation with other school districts, through regional Educational Cooperative Service Units or Education Districts, or in conjunction with other community screening programs. School districts are encouraged to link with other health and developmental programs, particularly community health agencies, Learning Readiness, Early Childhood Family Education, and Early Childhood Special Education.

Roles of State Agencies

The Minnesota Department of Education, through funds allocated by the State Legislature, reimburses each school district for the costs of screening services at a rate set by the Legislature on a biennial basis. Reimbursement can be claimed for one screening per child. No screening services funded by other state and federal programs are to be reimbursed by ECS funds. Screening performed by public or private health providers and funded by health insurance or other funds which the school district accepts as a comparable screening may not be claimed for reimbursement on a school district's end of the year report.

The Minnesota Department of Education (MDE) administers the ECS program in consultation with the Minnesota Department of Health (MDH) and the Minnesota Department of Human Services (DHS). The goal is to consolidate the efforts of statewide early childhood programs and services. Successful interagency coordination promotes cost containment and efficient programs by:

1. having screening standards consistent across programs;
2. having training for screening personnel from a common source;
3. avoiding duplication of services to children and families;
4. coordinating with established networks for diagnostic and treatment services;
5. linking children to Learning Readiness, Early Childhood Family Education (ECFE) programs, and Head Start programs; and
6. assisting local school districts in meeting the federal Child Find mandate to identify preschool children who are

eligible for Early Childhood Special Education.

The Minnesota Department of Education (MDE) periodically communicates legislative and administrative changes through memoranda to the ECS Coordinators who are designated by the school districts. MDE hosts statewide or regional update meetings for the ECS Coordinators with the cooperation of MDH. MDE also reports to the legislature as requested.

The Minnesota Department of Health (MDH) sets the standards for the health components of the ECS. In addition, MDH provides training for some required components of ECS (vision, hearing, growth, and guidelines for immunizations) and for some optional components of the program (health history review and summary interview). ECS screeners who provide the optional components, primarily school nurses and public health nurses, may participate in the training offered by MDH for the Child and Teen Checkups program, if space is available. In addition, MDH provides regional seminars for continuing education on a variety of topics related to child growth and development, health, and parenting.

[See Appendix G. for the list of state agency contacts that can assist with questions about ECS or related programs.]

History of Changing Requirement(s)

A comprehensive program of health and developmental screening was established in 1977. Originally known as Preschool Screening (PSS), the program included a physical assessment with blood pressure screening, health history, nutrition assessment, laboratory work, growth screening (height and weight), immunization review, the sensory screening (vision and hearing), and all elements of the developmental screening. This comprehensive program was phased in over two school years 1977-78 and 1978-79. The comprehensive Early Childhood Screening program offered identical components to the then EPS (Early Periodic Screening) and EPSDT (Early Periodic Screening Diagnosis and Treatment for Medical Assistance-eligible clients) (now called C&TC - Child and Teen Checkups). The Early Childhood Screening program focussed on 4 to 4 ½ year olds, although the majority of participants were 5 year olds in the program's early years.

ECS was reduced in 1982. Because the state was experiencing major financial crisis, this move was viewed as a short-term cost saving measure. The revised program included health and developmental screening. The health history - not the physical assessment or laboratory tests - was the primary vehicle for gaining health information. The sensory screening, developmental screening and immunization review were unchanged.

The Children's Initiative in 1988 contained several agendas including the establishment of the Children's Health Plan (now the children's portion of MinnesotaCare) and the redesign of ECS. At this time, ECS focussed on 3 year olds and reinstated the comprehensive program components. School districts were to have five years to implement this revised program which also included the requirement for school districts to access funds through third party reimbursement (private insurance companies and Medical Assistance federal funds). These changes were seen as too costly, the reimbursement

requirements were not practical, and this resulted in a burden for school districts.

However, the benefit of early identification and intervention was well established and considered high priority by decision makers. In communities statewide the participation rate exceeded 60% (nearly 100% in rural communities, 50% in urban areas where mobility of families and other factors made outreach and access more difficult). In 1992, the Legislature decided the benefits of screening should be realized by all children in Minnesota, so screening children at 3 1/2 - 4 years old became a focus of ECS and resulted in reaching children a full year before they started school. That year the health history was removed as a required component, growth screening was reinstated, and a new component of assessing special family circumstances that might affect development was added. The child's health aspects were to be covered by asking parents if they had health care coverage and making appropriate referrals, and by contacting the health care provider for any information from a well child visit within the year prior to screening. The addition of the family factors assessment in the same year that the program became mandatory was a great challenge for schools, and seen as intrusive by a few parents. Therefore, in 1993, the family factors component became optional, and a provision was added for parents to exempt their children from the requirement for Early Childhood Screening if the parents had conscientiously held beliefs against such a screening. Strong links were established in statute between ECS and the new Learning Readiness initiative, a program designed to meet the needs of all children in order to enhance their early development and prepare them for a lifetime of learning.

The state Legislature establishes the parameters for ECS in statute (law). MDE is then authorized to write rules to further explain the program and delineate details of how it is to be implemented. What is in the rules is required in the implementation of the program; rules are not optional guidelines. Rules carry the weight of laws. For Early Childhood Screening, rules were written in the initial years of the program and underwent major revisions in 1982. From 1982 to 1993, the rules remained unchanged and guided implementation of the program when pertinent. In 1993, the Legislature sought to simplify the requirements for all educational programs and eliminated many rules that were redundant or out of date. Through this process several segments of the ECS Rules were changed. A few segments remain that are out of date with the law, and in those cases, the law prevails. (See Appendix A for the current law and current rules including a note on the relevancy of portions of the rules.) A major change in the rules that occurred through this 1993 edit process was to establish the Minnesota Department of Health as the agency determining the standards for the health screening components. Rather than set in law or rule standards that could be out of date due to changes in technology or research, MDH can now periodically revise the standards and protocols of health screening components that are listed in the law as dictated by new knowledge.

Children Served

Approximately 62,000 children are screened each year by Minnesota's 392 school districts or through their respective contracting agencies. The total number of children eligible statewide for screening fluctuates with the birth rate and with the mobility of

families. Some 5% receive the screening service at another source (private or public health provider) and provide the data and result of screening to the school at the time of kindergarten enrollment.

A range of 20% to 50% of children are referred to services in the school and community. This includes the children and families at **low risk** who are invited to participate in the school's Learning Readiness program geared to bolster the resources families and children and increase the child's readiness for formal education. It includes children referred for basic preventive services such as the next immunization, recommended periodic physical assessment by the regular health care provider, or the first dental visit. The referral rate also includes children at **higher risk** who are referred for further assessments, such as to special education, or for an identified health problem (e.g. suspected ear infection, suspected neurological problem, or lack of recommended immunizations). Families may be referred to public health or social services for mental health, chemical health, issues of child abuse/neglect, economic difficulties, adult literacy needs, or other significant problems that could interfere with a child's development and readiness for learning.

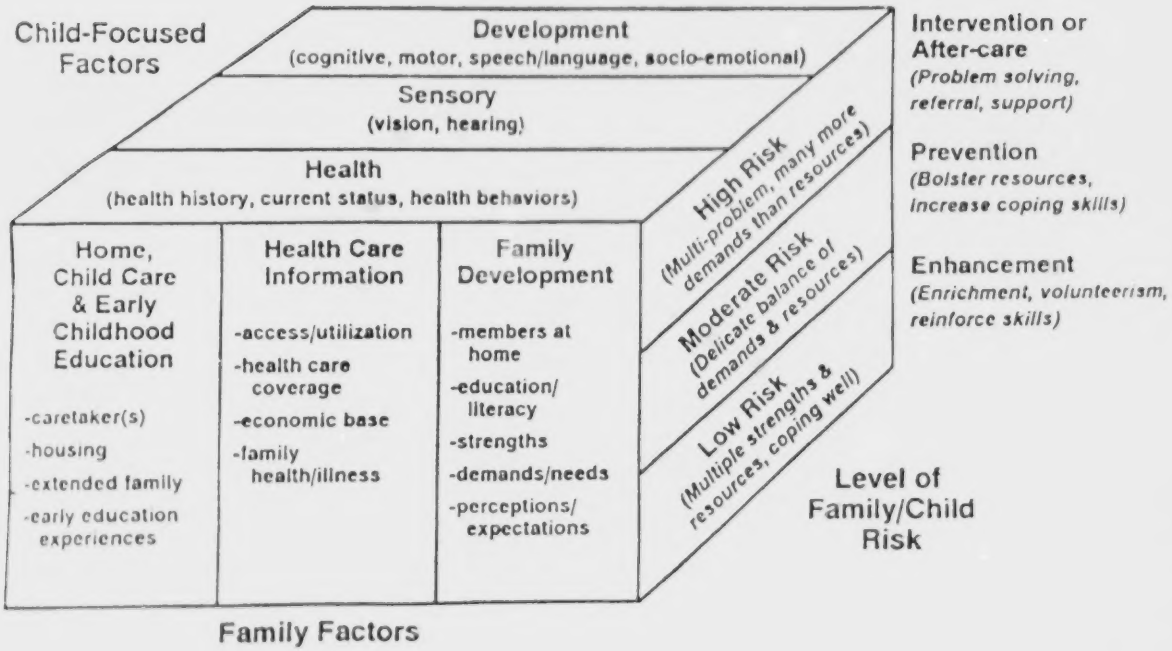
Costs

The state reimburses school districts for the cost of providing the program at a per-child rate of $25 (1994-95 school year) for the required components. Local school districts costs are often higher than the state reimbursement rate, averaging $40 per child for the required components. In order to accommodate this short-fall, school districts tap the General Fund by borrowing school nursing staff and administrators for ECS, or schools tap special education and community education by drawing on the respective staff to assist in ECS. County public health agencies may offer direct funding to support the ECS program, or, more often, provide substantial in kind services by staffing the program with county public health nurses that conduct the program entirely or assist the school district in a jointly administered program. In some cases, school districts receive funds from local service clubs or other community donations. In some cases the school districts, in cooperation with county public health agencies, are accessing funds through health insurance companies and through the federal Medical Assistance funds for eligible children. The state allocation for the 62,000 children screened per year is $1.55 million for 1994-95. This state allocation and the per-child reimbursement rate is set biennially by the Education Committees in the Legislature's House and Senate and is approved by the Governor.

Summary

Early Childhood Screening is a vehicle for guaranteeing that all children in Minnesota are fully equipped to participate in the array of education programs upon entry to their formal school experience. School districts are required to provide the screening, collaborate with school and community agencies, and establish a link between ECS and Learning Readiness.

DIMENSIONS IN EARLY CHILDHOOD SCREENING



This illustration depicts the dimensions in ECS - the screening components focussing on development, sensory, and health components of the child and the elements of the review of family factors. At the time of screening, a level of risk is determined with the parents and the subsequent plans are developed. No family is without risk due to the variables of everyday life in the family and community; therefore, the family at low risk is connected to other families, programs, and services in the community that may enhance their positive experiences with their child. In contrast, the child and family assessed to be at high risk needs immediate action to assist in solving problems. The indentified concerns may be health issues problems, requiring a medical diagnosis and treatment, developmental delays requiring a medical diagnosis and special education assessment, or the problem may be the number of family stressors that can complicate the child's development, which will require a referral to school or community resources for support and intervention. Priority in follow-up is given to children and families at high risk.

C. MINNESOTA SCREENING PROGRAMS

Minnesota has three statewide screening programs for young children: Early Childhood Screening (ECS), Child and Teen Check-ups (C&TC), and Child and Teen Check-ups - nurse approved programs (C&TC-nurse approved). The charts on the following pages outline the three screening programs. [Head Start also offers a review of health and development as a part of the enrollment of children in the program and provides ongoing assessment and intervention of health and developmental problems. The components are similar. The program is technically not a statewide screening program, so the components are not included in the chart on page 13.]

ECS, C&TC, and C&TC-nurse approved screening programs are similar in several ways. All three offer the same basic set of screening components, but the Child and Teen Checkups offers a more comprehensive program. The standards for training personnel, for administration of components, and the referral criteria are shared across programs. For the health components, all use the same screening tools and procedures, recommended personnel and criteria for referral as established by the Minnesota Department of Health. Screening standards are based on the latest research related to screening procedures and also on the guidelines of the American Academy of Pediatrics.

ECS, C&TC, and C&TC- nurse approved programs differ as to the frequency of screening, the age of the children screened, the focus of the program, the lead agency for the program, and the source of funding. ECS serves only children from age 3 to kindergarten, targeting 3½ to 4 year olds. A child participates one time in the ECS program. The other programs are geared to provide screening periodically through a child's infancy, early childhood and could continue into the adolescent years. ECS has a distinct developmental and learning readiness focus integrated with a health focus. Usually the school district is the lead agency. The other two programs, in contrast, offer the same components but have a predominant health focus. Either private or public health agencies are usually the lead agency. Noteworthy is the fact that ECS serves the entire population of Minnesota students one time prior to kindergarten entrance. It is not targeted to those with low income or other special needs as are the other two screening programs. ECS is a state funded program through state education dollars. The Child and Teen Checkups is federally funded and the Child and Teen Checkups - nurse approved program - is funded through both federal and state health dollars.

Provisions for Screening Medical Assistance-Eligible Children

When school districts provide only the required components of ECS, ECS is **not** equivalent to the C&TC. However, when school districts or their contractees provide a comprehensive ECS program (optional and required components), ECS is equivalent to C&TC. In this case, payment can be obtained from the Minnesota Department of Human Services (DHS) for Medical Assistance (MA) eligible children that are screened through ECS. The C&TC payment is higher than the rate of ECS reimbursement that is available through MDE. In order for the school district to claim the MA funds, the

school district needs to become a Medical Assistance-approved provider. To arrange for DHS payment, contact the Coordinator of Child & Teen Checkups at DHS (612/296-6040) for a provider number and contract.

When school districts collect reimbursement for screening costs of Medical Assistance-eligible children from DHS, the number of children for whom this reimbursement is claimed is to be included in the final count of children screened on the ECS completion report, but reimbursement for the screening provided to these children cannot be claimed again from the ECS program.

CHILD & ADOLESCENT HEALTH SCREENING PROGRAMS

	State Department Responsibility	Program Funding Sources	Program Providers	Age/Income Eligibility	First Year Implemented	Number of Children Screened Per Year
1. C&TC (Child and Teen Checkups)	Minnesota Department of Human Services	Medical Assistance	Physicians or nurse supervised clinics; 550+ providers	Birth to 21 years. Medical Assistance only	1973	119,960 (1993)
2. C&TC (Child and Teen Checkups - nurse approved programs)	Minnesota Department of Health	• Medical Assistance (for those eligible) • Sliding scale private pay (Sliding scale is locally subsidized, usually with Community Health Services funds.) • MinnesotaCare (for those enrolled) • Private health insurance	Clinics operated by nurses with MDH approved training. Examples: CHS agencies, Head Start agencies, Indian Health Services.	6 months to 21 years	1974	16,855 (1992)
3. ECS (Early Childhood Screening)	Minnesota Department of Education and Minnesota Department of Health	•State funds reimburse-ment for required components only ($25 for 1994-95) •Medical Assistance for comprehensive screen •Private health insurance for comprehensive screen	Individual school districts Programs conducted directly by school personnel or through contracts with C&TC agencies or other providers.	All children at age 3 ½ to 4 years Required for school entrance	1977 1992 - requirement for school entrance began	63,990 (1993-94)

COMPARISON OF COMPONENTS OF SCREENING PROGRAMS

PROGRAM	Early Childhood Screening		Child and Teen Checkups
	Required Components	Optional Components	
Welcome	x		x
Access past health records	x		
1. Growth: Height and Weight	x		x
2. Immunization Review/Referral	x		x
3. Hearing Screening	x		x
4. Vision Screening	x		x
5. Developmental Screening	x		x
6. Family Factors Interview		++	
7. Mental Health Screening			++
8. Health History Review		x	x
9. Nutrition Screening		x	x
10. Physical Assessment (with Oral inspect/Dental referral)		x	x
11. Lab Work		x	x
12. Health Education			++
13. Summary Interview	x		x
Referral and Follow-up	x		x

++ component unique to either ECS or C&TC

NOTE: Head Start entrance assessment and periodic reviews have similar components. ECS Coordinators are urged to compare program components with local Head Start providers and to provide coordinated screening/assessment services when possible.

II. ECS PROGRAM ADMINISTRATION

A. ANNUAL PLAN

A plan should be developed for implementation and evaluation of the ECS program every year. Besides potential legislative changes, there are local program changes that need to be made due to changes in the related programs or population to be screened. [See Chapter III for issues to be considered in revising the ECS plan and program.]

A plan form does not need to be submitted annually to MDE. However, when there are major program changes, such as in 1977-79 when the ECS began and in 1988 when the comprehensive nature of the program was temporarily restored, school districts will be required to submit a plan for approval to MDE. School districts should consider submitting an individual plan to MDE for consultation and/or problem solving when:

- substantial changes are made in the school district's delivery of the program;
- the designated ECS Coordinator changes,
- the contract or contractee changes;
- there is a shift in the personnel providing screening (for example, from all professionals to a cadre of paraprofessionals and professional supervisors);
- there is a shift in the discipline or program having primary responsibility for the program (such as from regular education school nurses to community education Early Childhood Family Education specialists, or vice versa);
- there is disagreement among the team of screening providers; or
- when the school district or contracted agency has an exemplary program so other school districts can learn from the model.

An ECS plan should be annually shared with the local school board as the board has responsibility for the program according to the state ECS law. While no annual plan form needs to be submitted to MDE at the beginning of each year, the report at the end of the school year includes a Statement of Assurances to be signed by the clerk of the school board verifying the program has been planned and implemented according to state requirements. Therefore, it is important to notify the local school board of the ECS program plans prior to implementation.

B. ANNUAL SUMMARY REPORTS

A. ECS Completion Report and Request for Reimbursement Form (ED-01611-XX).

The ECS Completion Report and Request for Reimbursement Form focuses on these key pieces of information:

1. Population served - number of children screened by age
2. Program model - personnel providing screening

3. Cost benefit - cost by component - required and optional components, including actual costs, in-kind contributions, reimbursements, and donations
4. Authorizing compliance with program standards - signature on Statement of Assurances.

[See Appendix F for the report form and the detailed instructions for completing the form.]

A line-item budget for managing the ECS program is not requested for this report, although such an analysis may need to be kept for local audits. What is needed is the estimated cost of screening by component. All ECS expenditures for which reimbursement is claimed are to be entered in the school district's appropriate UFARS Account. Please note the UFARS Finance Dimension Code #354 is required for reporting purposes.

The ECS Completion Report form is to be filed with the Families and Children Team at MDE. The ECS Completion Report may be submitted at anytime during the school year after completion of the school district's program. **The due date is August 15**.

Allowable costs:

- Salaries of school personnel for the portion of time spent on ECS activities.
- Extra pay for additional services of special education personnel as reflected in the school district's UFARS account.
- Costs for clerical services, postage, and mileage for family or agency contacts.
- Costs for ECS training seminars, media announcements and similar ECS-related costs.
- Reimbursement to private providers/agencies as specified in contract with the school district.
- Costs of coordinating ECS programs with related programs and for obtaining information from other providers.
- Costs of equipment and supplies (if these cannot be obtained on loan from a regular education program, special education program or community health services).

Costs that are not allowed:

- Duplicate payment of salaries covered by state aids, special education categorical aid, ECFE, or other special funds, although pay for substitutes of these personnel is allowed.
- Diagnosis and treatment including remedial services and subsequent assessment activities.
- Costs for optional components.

The Education Funding section at MDE handles funding and payment for MDE programs. School districts receive payments during the course of the year for 85% of the estimated total ECS Program costs based on a school district's previous year's report of costs. At the end of the school year, actual costs (as reported on the ECS Completion Report) are compared to the estimated costs, and the final sum (approximately 15%) is calculated and paid in the fall. If the school district's actual costs are less than the per-

child-reimbursement rate, the reimbursement is made on the lesser amount.

Final reports from **all** school districts must be submitted before the final payment to any school district can be made. The total reimbursement for all school districts in the state cannot exceed the maximum amount set by the Legislature. If the requests from local school districts exceed the total amount set by the Legislature, the amount reimbursed to school districts is prorated, providing a slightly lesser reimbursement than the set state rate. The proration will first be calculated on the number of kindergarten children screened during the 30 days after school enrollment. This is based on the assumption that the costs for screening these kindergarten children is less than the costs for screening the 3½ to 4 year olds, the target population.

Questions about reimbursement can be directed to the MDE Education Funding Team (612/296-8130).

See the **Instructions for ECS Completion Report and Reimbursement Request** for 1994-95 for detailed information on the rationale and instructions on completing the report. Subsequent years' completion reports will request the same basic information, but may have changes due to legislative program changes or MDE/MDH policy changes.

Some general principles for completing the form include:

Children Screened

- The information in this section is basically a measure of the effectiveness of outreach. The participation rates are calculated - total children screened against the total number eligible. The largest percentage of children should be in the 3 and 4 year old categories, with a decreasing percentage in the 5 year old category from year to year.

- As communication with others who provide comparable screening services improves, these screening providers are expected to report their findings to the school's ECS program (with parental permission), and then these children would **not** be screened again at the school's ECS program. Programs with comparable screenings are in private or public health settings or through Head Start. Funding for these programs comes from private insurance, Medical Assistance or the Head Start program with the amount usually far exceeding the state reimbursement for ECS. Therefore, when these comparable programs, funded through other sources, provide screening and the results are communicated, the number of children screened at the school-based ECS should decrease.

Providers

- The information in this section is a measure of the collaboration within a school district/contracted agency program or among ECS and other early childhood programs in the school and community.

Cost

- The costs are to be inclusive of direct expenditures for the program, in-kind contributions, and other payments. Without these true costs, the state legislature cannot be expected to know and potentially match the resources needed with state funds.

- For costs for each component, include the following: personnel plus benefits, training fees and time, equipment, or other materials.

- Every component has a cost. It always involves personnel, training and often equipment. Even when volunteers conduct the screening, there is a cost. With volunteers, the costs include recruitment, training, and supervision of volunteers. Also, for any potential problems noted for a child in a screening component conducted by a volunteer, a professional must rescreen the child for that component before making a referral.

- Outreach activities include both costs of time and materials, as well as significant in-kind costs; these should be calculated and reported.

- Follow-up for some families takes significant problem-solving and time, and the costs should be calculated and reported. This includes contacting the family, perhaps a number of times, to ensure further assessment has been conducted for problems noted. Follow-up is not necessary for referrals for enhancement and general prevention.

- Administrative costs should be in the range of 5-10% of the total costs. Some activities in this category include setting policy, designing the plan, locating places and equipment, and making final reports. Activities that are related to outreach, follow-up, or that include supervision of screeners for a given component should be listed by the respective components, and should not included in the administrative costs.

B. ECS Report of Potential Problems, Referrals, Results (ED-01801-XX).

The merits of ECS are judged by the problems noted and the outcomes of the referrals made for children for further evaluation and intervention for health and developmental problems. Therefore, a report of findings, referrals, and results is necessary. The information is incorporated into regular reports to the Legislature and other decision makers. The information on referrals and the results is essential to local program evaluation, comparing the findings to the previous years' screening results in the local program, to statewide data, to national norms, and to research findings.

The first section of this report measures the impact of ECS by asking for the **number of potential problems found and the results of the referrals**. The next section of this report follows the format of the ECS PER Tool, calling for a review of the **screening process** - outreach, screening, and follow-up. Next the **outcomes** are to be listed - the impact of the program for individual children and on the community's programs and services. The final section calls for a **summary of strengths and weaknesses**.

This report is based on the data gathered in follow-up. Follow-up is the process of confirming findings of the screening and ensuring that those diagnosed or evaluated as having concerns are participating in an appropriate intervention or treatment program.

General principles in completing this report include:

1. **Screening and Follow-up for Risk Factors that Influence Learning:**

A. For most health and developmental components that use the standardized tools and clinical interview processes, the findings can be categorized as "OK" or as "needs referral" (formerly called "pass/fail"). The "needs referral" category can be labeled for reporting purposes as "potential problems." These potential problems can be further delineated as **new problems** or as **known problems** on the summary report. For most, but not all, of these problems, the family will be **referred** for further assessment or linked with a school or community service. The parent and screener, particularly the summary interviewer, decide together whether a referral is necessary for a new problem or known problem. For example, a child measuring short for height has parents of a similar short stature; there may be **no referral** at that time, but parents may be asked to consult with the physician regarding this finding at the child's next regular medical visit. However, care needs to be taken, even in this example, to not "under" refer a child. Of course, for any problem noted through the screening process, and having no other relevant information to consider, the child **is referred**.

Known problems are those of which the parent is aware. The screener may note that parent provides the information during parent report of development or the health history or during the summary interview process. When a child is receiving care or service for a known problem, there is **no referral**. If the child has: a) lapsed from care or service, or b) if the problem seems to have changed or increased in any way, the child **is referred**.

B. Concerning family information or other risk factors, the findings at screening are less likely to be defined as "OK" or "needs referral." Therefore, broad categories for these issues are outlined as"low risk," "moderate risk" and "high risk." [See the cube describing ECS and the risk categories on page 9.]

•For "low risk," the parent is provided with information about resources in the community to enhance the child's normal development and the family's positive functioning.

•For "high risk," the parent needs to be connected immediately for support and services. Sometimes the summary interviewer needs to assist the parent in making an appointment with a provider before leaving the screening site.

Rather than attempt to **confirm the findings** as in the previous section, the follow-up deals with **whether families have connected** with services in the school or community. (See the Referral and Follow-up Tracking System discussion on page 34.)

2. **Screening Program Components Evaluation Information:**

One measure of ECS program success is the degree to which problems are identified, confirmed through diagnosis, and the problems resolved for the children. Another measure of success is the systematic operation of the program so it meets parents' expectations and needs. Yet another measure is the satisfaction of the staff in being able to efficiently and effectively meet each child and provide reasonable services in a

reasonable amount of time. As stated previously, the ECS PER (Planning, Evaluating, Reporting) Tool outlines a series of questions on the **process** and **outcome** of the ECS program that will be useful in completing these sections of the report.

The final section of evaluation calls for the judgement of the ECS Coordinator and the members of the screening team to identify the program's strengths and weaknesses. This section also asks for recommendations to the Minnesota Departments of Education and Health.

III. ECS PROGRAM IMPLEMENTATION

The **Checklist for ECS Program** lists the requirements for the program as specified in state statute and state rule. It is organized by ECS program activity - **planning**, **outreach**, **screening**, **follow-up,** and **reporting**. Sections of the checklist are included in the respective sections of this chapter. The entire Checklist for 1994-95 is in Appendix B. It should be reviewed annually for any revisions due to changes in state law and/or policy.

A. COORDINATING/PLANNING

Planning for ECS is a major program activity as evidenced by the number of issues and the detailed tasks listed in the previous chapter. Also, using the Checklist for ECS Program as a guide, there are at least two pages of details to be planned. Therefore, ECS Coordinators and screening staff are urged to allow enough time for planning activities.

Planning activities include the following:

1. Determining policy questions that require action by school administrators and/or the school board. Some of these policy questions include coordination with other education programs such as sharing staff, the local cost burden of providing optional components of ECS, criteria for evidence of participation in screening for kindergarten enrollment, and procedures for noncompliance.

2. Determining characteristics of the population to be screened which will influence the number of screening days, days of the week, time of day, site for screening, etc.

3. Selecting the model for screening; the model will determine: (a) the size and make-up of the screening team, their training and supervision, (b) the components to be provided, (c) links to other school or community programs.

4. Outlining the reporting plans - audience, purpose, data, evaluation.

5. Determining the budget and sources of funds and/or in kind contributions.

[See also the section on ECS Personnel - the role of the ECS Coordinator. See also the ECS PER Tool in the next section of this chapter on evaluation for ideas on planning.]

Purpose and Communication

The school district needs to carefully review the purpose of the program as stated in the ECS statute and related statutes. Then the task is to determine how local program goals complement the state requirements. [See the elements required for review on the next page.]

Connecting with other programs guarantees that the best quality and most comprehensive program is provided at ECS without duplicating other services. The links ensure that children can readily access services for assessment and intervention in a timely and efficient manner.

Checklist for ECS Program - Section on Purpose & Communication [current 1994-95]

COORDINATING/PLANNING

__ **Define purpose of the program:**

- __ Assist parents and communities in improving the health of Minnesota children (MS 123.701; MS 123.702,1b(a)).
- __ Design and plan educational programs (MS 123.701; MS 123.704).
- __ Plan health programs (MS 123.701; MS 123.704).
- __ Screen children for possible health and developmental problems (MR 3530.3100,1) through systematic procedures (MR3530.3000,7) to sort out apparently well children from those in need of more definitive study of health or developmental problems (MS 3530.3000,9).
- __ Develop education programs to meet the individual needs of the child (MS 123.704).
  - __ Link children to Learning Readiness (MS 121.831,2.2); identify priority children through ECS (MS 121.831,8).
  - __ Identify risk issues for families in the Early Childhood Family Education Home Visiting program (MS 121.882,2b).
  - __ Link children and families to Early Childhood Family Education.
  - __ Identify children with special needs and refer to Early Childhood Special Education or IEICs (Interagency Early Intervention Committee).
  - __ Coordinate with Head Start programs to improve access to and reduce duplication of screening services, and to improve access to programs.
  - __ _____
- __ _____
- __ _____

__ **Communicate, cooperate, coordinate and collaborate** with other programs and agencies:

- __ Shall establish the program either by one board, two or more boards acting in cooperation, by ECSUs, [by Education Districts] by ECFE (Early Childhood Family Education) programs, or by other existing programs (MS 123.702,1). Programs in the community may appeal to the local school board to participate in the screening program (MR 3530.3100,5).

- __ May contract with or purchase services from public health agencies or medical clinics providing Child and Teen Checkups funded by state public health and/or federal Medical Assistance (MS 123.702,4).

- __ May consult with local societies of health care providers (MS 123.702,6) in planning.

- __ Communicate with physicians and community health agencies (public or private health care organizations or individual health care provider (MS 123.702,1) regarding:
  - __ setting the criteria for "comparable" developmental screening program (see required components on page 3) that will be accepted as a record of screening - date and results by component - (MS 123.702,1; 1b (a)).
  - __ process to request results of any laboratory test or physical examination for children seen within the 12 months preceding ECS (MS 123.702,1b(b)).
  - __ ability/desire of the provider to accept referrals for children without health care coverage because schools are required to refer such children to an appropriate health care provider (MS 123.702,1b(c)).
  - __ plan to receive referrals for assessment, diagnosis and treatment (MS 123.702,1b(a)).
  - __ follow-up process for confirming children have received care, results of diagnosis and treatment, future needs of children (MS 123.702,2).

- __ Communicate with staff in other early childhood programs -- education, human services, economic development or other community programs -- regarding:
  - __ Coordinating screening activities (MS 123.702,4).
  - __ Referral resources (MS 123.702,1b(a)).
  - __ Planning education and health programs in the community (MS 123.701).
  - __ Other links as required by other programs (ECFE Home Visiting, Learning Readiness)

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Costs and Revenue

Checklist for ECS Program - Section on Costs and Revenue [current for 1994-95]

COORDINATION/PLANNING - continued

__ **Determine the costs and revenue:**

- __ State reimbursement - $25 for children age 3 ½ through school entrance (MS 123.7045).
- __ May transfer dollars from the general fund if ECS state aid is not sufficient (MS 123.7045).
- __ Consider using funds from other early childhood programs that complement ECS, such as Learning Readiness funds which may be used for the optional family factors component, to extend the summary interview or for follow-up.
- __ May recover costs from third party payers. (Previous cost recovery requirements are repealed but some districts who will provide a comprehensive screening program are voluntarily continuing cost recovery efforts.)
- __ May charge parents a fee for optional components (MR 3530.4310).

The local school district cost for required components of Early Childhood Screening has, in the past, typically exceeded the reimbursement rate. However, in 1994 the Legislature attempted to align the expectations - or required components - with the reimbursement offered by the state to local school districts. Here are some considerations when analyzing local ECS program costs:

Components. The Legislature decreased the number of required components in order to reduce the local school district costs for ECS. The health history component and the family factors component are now optional components. Health issues must still be addressed at ECS so that the screener and parent can have a comprehensive look at the child. Therefore, information regarding the health of the child includes requesting from the health care provider any information on children who have been seen for well child visits in the 12 months prior to screening, and asking parents about their health care coverage so they can be referred to programs providing coverage.

Use of Volunteers to Reduce Costs. Several times the state law for ECS gives the directive to use volunteers. ECS Coordinators realize that using volunteers does not eliminate program costs; however, it may reduce program costs. In some case there is no effect on program costs. The effort required to recruit, train, and supervise volunteers may, at times, exceed the benefit. Therefore, the use of volunteers needs to be considered annually, and volunteers must be used if their contributions can reduce the cost of screening. Note that some components deal with highly sensitive issues and require consideration of private information, such as the family factors, the health history, and the parent report of development. These components should be handled by school employees or a contracted agency whose employees are held to a high standard of maintaining privacy of the parent and child. (See the Personnel section on use of volunteers.)

Use of Paraprofessionals to Reduce Costs. In 1992 the Legislature established participation in ECS as a requirement for a child's school enrollment. At the same time

they required the program to be provided by professionals. In 1993 the Legislature discussed offering the districts more flexibility in staffing ECS. They set the requirement for staff to be "trained similar to" professionals [as listed in statute]. Some school districts have reverted to use of paraprofessionals for some components of ECS. However, as with volunteers, the effort may exceed the benefits. Paraprofessionals must be selected, trained annually and supervised on site; and children who are found to have potential problems must be rescreened by a professional prior to referral. In addition, **any component that uses a clinical tool** (interview process requiring interviewing skills and professional judgements) **must be provided by a professional screener**. (See the Personnel section on supervision.)

In-kind Costs. In-kind costs are the contributions to ECS of staff and materials that are paid for out of other funds. Classic cases of in-kind contributions to ECS include the coordination of the program by staff employed by the General Fund (Fund 1) such as school nurses or principals. Another example is the provision of direct screening by the school nurse, by ECFE, ECSE staff, etc., without charge to the program. Often follow-up is assumed by various members of the screening team and carried out during time they are paid for by another program such as the school General Fund, Community Education funds, Special Education funds or resources from other agencies such as County Public Health Nursing. Reasons for the common use of in-kind contributions to ECS include: the moderate state reimbursement for ECS often does not meet the actual costs of the program, the linkages with other programs as set in statute, and the natural linkages among programs in communities provided to improve services to children and families, whether prescribed in statute or not.

When the annual report of costs is completed, it is very important to estimate the in-kind costs. Without these "expenses" included in the report, the reported costs are lower than the actual costs. One way to think about a complete accounting of actual costs is to think of ECS as an island - unrelated to other programs. Consider who would deliver the services and how much time/resources would be involved in designing and delivering the program if it stood alone?

Links to Other Early Childhood Programs. Collaboration with other early childhood programs improves the effectiveness of ECS and also the related programs. ECS identifies children who can benefit from other programs that the parents can learn about through ECS. ECFE and HeadStart can assist the ECS program with outreach. Learning Readiness can participate in follow-up. All of these programs as well as Early Childhood Special Education are referral sources.

The links can provide direct service for assuming responsibility (and expenses) for a given portion of ECS. The links can make ECS run more efficiently, thereby improving services and decreasing costs. Also, the more efficiently and effectively ECS runs, the greater the likelihood that referrals are accurate and cost effective for parents and other providers of other programs.

Community Services - Fund 4. ECS is one of the programs in Fund 4 of the fiscal reporting system for school districts. Other programs in that fund include ECFE and Community Education. If ECS reimbursement is not sufficient to cover the costs of the **required** components ECS, the

additional funds to be tapped are from the General Fund 1, **not** the Community Education fund (MS 123.7045). In some cases, Community Education funds may be use to provide for **optional** components if approved by the Community Education Advisory Committee. The local school board must also approve this action.

In that same vein, ECFE revenues **may not** be used for the **required** components of screening such as contracting with an individual or group for providing the screening. However, staff employed in ECFE can assist with screening as part of their outreach to families with young children as a strategy to inform parents about ECFE (an in-kind contribution from ECFE to ECS). ECFE staff can conduct developmental screening, the family factors interview and/or assist with follow-up. The ECFE Advisory Council could choose to provide supplemental funds for the **optional** components of ECS or could choose to offer a partial screening for very young children as a precursor to ECS.

Enrollment Criteria and Procedures for the School District

Checklist for ECS Program - Section on Enrollment Criteria [current 1994-95]

COORDINATION/PLANNING - continued

_ **Set enrollment criteria and procedures for the school district.**

- _ Screening is a mandatory requirement for a child to be enrolled in (MS 123.702,1a) or continue attending (MS 123.702,1) kindergarten; the record may be submitted within 30 days after the first day of attendance (MS 123.702,1a).
- _ Develop a plan for responding to a parent who declines screening. The parent or guardian must submit a signed statement that the child has not been screened because of conscientiously held beliefs (MS 123.702,1b (e)). The statement does not have to be notarized.
- _ Review the requirements for school enrollment: a record submitted by the parent of the dates (month and year) and results of screening. Review the school district's summary form for inclusion of all components (MS 123.702.1a)).
- _ Determine the criteria for accepting results of a comparable screening when
  - _ the child's health records indicate to the school district that the child has received a comparable screen within the 365 days prior to the school's program (MS 123.702,1b(a)); or
  - _ when provided by a private or public health care provider (MS 123.702,1)

Screening is a requirement for school enrollment for children entering school at or anytime during kindergarten. However, if a parent declines to have his/her child screened due to conscientiously held beliefs and he/she provides a written statement, the child does not have to be screened. The statement does not have to be notarized. The statement should become part of the child's permanent school record.

Exemption. One way to notify parents of the exemption to participation in ECS is to include the information in the first ECS notice to parents of the requirement for and availability of screening (the outreach letter).

Another way is to notify parents of the requirement of screening, and, if a parent raises questions or objects, then provide the parents with information about the exemption. When deciding which method to use, review the method used by the school district to handle notification for the immunizations record requirement for school entrance and the related parental exemption. This same procedure should be used for handling notification of the ECS requirement and exemption. The request for exemption from participation in ECS is expected to be very rare.

Children Enrolled in Special Education. If all components required in ECS are assessed in the planning and service delivery for the child in an ECSE program, participation in ECS would be redundant. To guarantee all required components of ECS are covered in the ECSE and to avoid confusion at the time of elementary school entrance, an ECS Summary sheet should be completed. A good time to review the required components of ECS would be the annual IEP/IFSP review sometime between child's 4th and 5th birthdays.

B. EVALUATING

The early identification of problems that might interfere with a child's learning, growth and development, and remediation of identified problems before school entrance is the ultimate benefit or outcome of ECS for young children. Several important questions that can assist in determining the effectiveness of ECS are:

1. How is ECS structured? Does the set-up enhance or hinder progress toward the goal?
2. Do the steps of ECS (outreach, screening process, and follow-up and referral) work efficiently, effectively, and with reasonable cost?
3. What process is in place to document the results - output and outcome - of ECS?

A key to evaluation is outlining what is to be evaluated in the planning stage of the program. That is why this section is included after the planning section but before the chapter detailing implementation.

Here is the relevant section of the Checklist for ECS Program:

Checklist for ECS Program - Section on Evaluating [current 1994-95]

EVALUATING

__**Ensure that an appropriate follow-up process** is available (MS 123.702,2) including assessment, diagnosis and treatment (MS 123.702,1b (a)).

__**Use summary data** for developing educational programs **to meet the individual needs of children** (MS 123.704)

__**Use summary data to design appropriate health and education programs** for the school district (MS 123.704).

There are several ways to gather information for an evaluation of the implementation of ECS. These include the ECS PER Tool, a walking tour to observe the screening process, parent perception of the ECS gathered through a survey, review by the screeners and those resource people in the community who receive referrals, and a referral and tracking system. The ECS PER Tool can be found on the following pages. Other ways of gathering information are described at the end of this section.

- **Review of ECS Using the ECS PER Tool**

The PER [Planning, Evaluating, Reporting] law requires school districts to establish educational goals, a process for goal achievement, and a procedure for evaluating and reporting progress toward the goals (MS 123.741-2). PER pertains primarily to the curriculum planning and selection process, but the concepts can be applied to all educational programs, including ECS. The ECS PER Tool begins with the basic questions to be addressed in planning - the purpose and goals of the program. This includes the statutory requirements and the local school district goals and objectives. This next section of the ECS PER Tool is on evaluation and uses the following format:

- Structure—the environment and its resources.
- Process—the sequence of events and activities of the programs in progress.
- Outcome—the results, change, effect.

Within the Process section, the tool reviews the phases of screening: outreach, screening and referral, and follow-up. Some summary questions conclude the evaluation section. The ECS PER Tool concludes with the issue of reporting - reporting what to whom and why.

The Tool is designed for use by the ECS Coordinator, all members of the screening team, and the referral resources. Together these key people can look at the total program, rather than a taking a piecemeal view of the program.

EARLY CHILDHOOD SCREENING
PLANNING - EVALUATING - REPORTING TOOL

This worksheet is a tool for school district personnel to evaluate their Early Childhood Screening (ECS) program. The areas for review follow those set in Minnesota Statute 123.74 for planning, evaluating and reporting educational programs. Although the law focuses specifically on curriculum, the steps outlined can be a guideline for ECS evaluation.

PLAN

The state law identifies the purpose of ECS and the law and rules set the parameters of the program.

In addition, each district implements the program according to the needs and values of its community as reflected in stated and unstated goals.

> *First identify the goals and the districts planning efforts to set these goals.*
> *Then evaluate ECS using some of the questions suggested this plan.*
> *Return to the goals and objectives to determine whether they are met or unmet.*
> *Base goals and plans for the next year on your findings.*

PURPOSE/GOALS:

The purpose of ECS as stated in statute is:

> [MS 123.701] Early detection of children's health and developmental problems can reduce their later need for costly care, minimize their physical and educational handicaps, and aid in their rehabilitation. The purpose of ECS is to assist parents and communities in improving the health of Minnesota children and in planning educational and health programs.

Through 15 years of conducting ECS, school districts and community agencies have designed and implemented programs to meet additional goals:

> Provide a positive, validating, constructive experience for parents.
> Provide a positive, engaging, and nonthreatening experience for children.
> Demonstrate that school personnel are positive, sensitive, and responsive.
> Set the stage for parental involvement in education.
> Provide ideas and resources for parenting and developmental-enrichment.
> Increase awareness of health, social and education programs in the school and community (ex. ECFE, MinnesotaCare).
> Enable parents to become more aware of the connection between family circumstances and the child's development/learning.
> Help families to access services and supports that meet family-identified needs and priorities.

ECS PER TOOL

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PLAN: PURPOSE/GOALS: - continued

Requirements: Statement of Assurances on the back of the Annual Cost Report Form.

1. The parent of each child eligible for screening has been notified of the requirement for ECS.
2. All staff met the qualifications as defined in statute and rule.
3. All required screening components are offered in accordance with statute and rule.
4. The required screening services are offered at no direct cost to participating parents.
5. A referral and follow-up process is available.
6. No reimbursement request is submitted for children whose screening has been paid for by other agencies or for costs reimbursed by other sources.
7. No reimbursement is claimed for more than one screening per child.

___ **See also the green CHECKLIST FOR ECS PROGRAM-COORDINATING AND PLANNING**

Other Requirements:

Child Find for young children with special needs (federal special education law and regulations)
Community Social Services priorities (Mental Health Initiatives)
Community Public Health priorities (Maternal Child Health State/Local Initiatives)

___ **School District goals and objectives that are pertinent to ECS:**
(Review from the school district PER process, Community education, Parent Involvement)
1.
2.
3.
4.

___ **Goals and objectives for the district ECS program (stated and unstated):**
1.
2.
3.
4.

Planning Process Questions:

Who establishes the ECS goals and objectives?
Do a variety of school district educators have input?
What opportunity exists for input from referral resources and community members?

Are the goals communicated to school board members and administration?
Are the goals and objectives measurable?
Are annual goals based on evaluation of the previous years' program, incorporating changing community needs, values, and resources?

ECS PER TOOL

EVALUATE

***Structure*:** Characteristics of the school/agency and the personnel of ECS.

Who is the ECS Coordinator? Why?
Who are the members of the ECS team? Who are not members?
Do the team members participate in planning? In evaluation? In reporting?
Are the assignments of the team members clear? Acceptable? Reasonable?
How are team members informed of program changes, continuing education opportunities, and program results?

Who manages the budget? Why?
What do the ECS funds buy? Regular salary time? Extra time? Materials? Mileage?
By what process do team members share cost effective suggestions?
What additional funding sources are utilized? What linked services are used?

In terms of scheduling facilities, materials and staff, are there changes that would expedite the process?

Regarding the screening providers' knowledge and skills, how is initial training and annual review handled? Changes needed?

Do the screening tools help to answer your major questions/concerns about children's health and development? Or do they interfere with the process obtaining important information?

Do the tools measure what is intended to be measured (validity)?
Do they do so consistently (reliability)?

Process: Characteristics of the program in progress; mechanics of the program.

- **Outreach:**

  Which parents and children participate in ECS at the target age of 3 ½ - 4 years?
  Which do not? Why? How can non-participants be encouraged to attend?
  Which outreach efforts are effective? Most cost beneficial? Could be eliminated? Should be initiated?

- **Screening:**

  Registration:

  What occurs at registration from a child's viewpoint (eye level) and from a parent's viewpoint?

  What is the primary purpose of registration?
  Could some tasks occur later in the screening process?

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EVALUATE: ***Process*** ■ **Screening** - continued

Screening Components: See the grid listing the screening components across the top and the questions on the side. For each component, ask the following questions:

How much time is required for each component? Is the time balanced with other components?
What are the providers' level of knowledge and skills? Strengths? Weaknesses?
By what measure or criteria?
Logically and mechanically, how well do the standardized tools and/or the clinical tools work?
What is the quality/usefulness of the information obtained? What changes are needed?
How well are the children oriented to the component and environment before being screened?
Are the children comfortable interacting with the providers? Are the parents?
What opportunity do parents have to ask questions? Who answers parents' questions?

Parental Guidance/Health Promotion:
Are printed materials legible? At an appropriate reading level? In a reasonable amount?
When are printed materials discussed with parents? Why?
What visual information (posters, charts) is displayed? Audio-visual information presented?
Is the maximum amount of information provided without overload?
In what ways is information reinforced during the screening process? After screening?

Clinic Management:
What efforts are made to make parents and children feel welcome, oriented, involved?
Is assistance provided in moving from station to station?
How much "down time" is there for the child? For the parent?
Is the space adequate and does it allow for privacy as needed?
Are forms completed accurately and consistently?

■ **Referral and Follow-up:**

Referral:
Are findings explained to the parent in a way that is understood?
Do parents agree with the findings and indicate an intention to take action?
Is a range of resources offered for resolution or further assessment?

Confirming findings:
What methods are used to encourage assessment/evaluation of findings? Changes needed?
Do parents and providers return assessment/evaluation information to ECS? Why? Why not?
How much time and energy is spent on confirming findings? Is this adequate?
How can follow-up contacts be utilized to reinforce parental guidance information?
What system is used to keep track of the status of follow-up?

Data: Documenting and Communicating Data:
Who transfers information to the school intake staff person?
Who transfers ECS data to the Pupil Health Record? When? What information is transcribed? When are the long-form ECS records returned to parent or in another way purged from the cumulative record?
What information is included in records for children needing special education evaluation?
When are ECS data discussed with the kindergarten teacher, early educator, principal, school nurse or public health nurse, special educator?

ECS PER TOOL

EVALUATE: - continued

Outcome: Change in the child's health and developmental status, knowledge, skills, and attitudes.

What information is used to describe outcomes?

Discuss **output:**
- number and percent screened
- number and percent referred with identified problems by component

Discuss **outcome:**
- number and percent where follow-up is complete
- number confirmed, nature and resolution of concerns
- number referred to and participating in other programs for ongoing service
- number of kindergarten children entering school with concerns resolved
- increased knowledge of child development and community resources; improved parenting skills

Cost:	What are the total costs of the program (personnel, materials, energy, etc.)?
Cost benefit:	What are the costs as compared to the outputs, outcomes, community responses to the program goals?
Cost effectiveness:	What are the costs as compared to the outcomes - significant findings and resolution of problems (and resources saved because of the program) as stated in the program goals? What is the response from parents (the customers)? Educators? Health professionals? Is the program acceptable to the children/parents, educators, health care providers?

Summary:

What are the program's strengths and weaknesses?
What changes are needed?
What are the plans for improvement? Who is assigned to make changes?

ECS PER TOOL

REPORT

What ECS information is reported? To whom? When?
Does the report include school district goals, findings of the evaluation and plans for improvement?
How is information disseminated to school district educators, school district administration, community members, county officers, state legislators and state administrations?
Is there an invitation and opportunity for those receiving the information to respond?

December 1993, MDE/ECS/REL

ECS PER TOOL

ECS PER [Planning, Evaluating, Reporting] Grid
School Year _____

COMPONENT	REGISTRA-TION	GROWTH	SENSORY Vision	Hearing	DEVELOP-MENTAL	IMMUNIZA-TION REVIEW	HEALTH INFORM/ ACCESS	SUMMARY
TIME:								
Staff: Preparation Annual training								
Tool: Guidelines clear Effectiveness								
Environment: Privacy Noise Parent Observes								
Orienting child to each component								
Comfort: Child Parent								
Dialogue: Questions Feedback Information								

OTHER COMPONENTS	HEALTH HISTORY	NUTRITION REVIEW	FAMILY FACTORS	DENTAL	PHYSICAL ASSESSMENT	LAB TESTS	OTHER:	OTHER:
TIME:								
Staff: Preparation Annual training								
Tool: Guidelines clear Effectiveness								
Environment: Privacy Noise Parent Observes								
Orientation:								
Comfort: Child Parent								
Dialogue: Questions Feedback Information								

Here are some important ways to gain information about the operation of the ECS program that then can assist ECS Coordinators and screening teams in answering evaluation questions in the ECS PER Tool:

- **Walking Tour** - Key to Observing Structure and Process of ECS

A very effective method of observing program operations is to follow a family through the screening process; beginning with registration and continuing through the summary interview. The ECS Coordinator is urged to make this walking tour at least annually, if not at every screening clinic, to assess the mechanics of the program, strengths, and weaknesses of screening staff and volunteers, "down time" for parents, and other aspects of ECS. This is also an important activity for the summary interviewer who needs some sense of parents' experiences at screening when synthesizing screening data. The worksheet grid at the end of the PER Tool may be used to document the observations made in this walking tour.

- **Parent Perception of ECS**

Another valuable evaluation aspect is the parents' perception of the screening day activities and of the screening program in general. A parent response form is provided in Appendix D. ECS Survey - Parent Survey. It may be modified to meet local program needs.

- **Providers and Referral Source Review**

The perception of ECS affects parent satisfaction, referral response, and ultimately financial and political support for ECS on the local and state levels. Communication with other early childhood programs can be essential to an effective program particularly in the areas of outreach, follow-up, and referral. This can be accomplished by annual meetings with all staff conducting the program - volunteers, paraprofessionals and professional staff. A second important annual meeting is with the circle of school and community referral sources. In order to share the findings of the referral sent (positive screening findings compared to the outcomes of the diagnosis/assessment), to share the summative screening information, and perception of needs of the population of children screened. This is an important opportunity to review and identify duplication or gaps in the current services and to begin planning for future health and educational programs for young children and their families.

Seeking input from community providers and referral sources can be done through informal conversations, through an invitation to participate in ECS planning and evaluation sessions, by sending a year-end report, or by a formal survey that asks for suggestions or feedback. Various programs and agencies that focus on young children can cooperate to understand the purposes, goals, and services each provides. Communication in this manner enhances the services and opportunities available and improves referral outcomes for children and families.

- **Referral and Follow-up Tracking System**

ECS Coordinators need a system to track children who have been identified with potential problems beginning with the referral process to the confirmation of the results of assessment/ diagnosis. Some ECS programs are developing computerized

tracking systems that allow for monitoring of referrals and results.

Tracking when and what referrals are made allows for contact with parents to determine what steps have been taken since screening. This important task of contacting parents after screening can be handled in several ways. The ECS Coordinator with support staff can handle all follow-up contacts. Or the nature of the problem can determine which of various members of the screening team can become "case managers" for ensuring the child receives the assessment and services needed. For example, children referred for special education assessment can be "case managed" by the early childhood special education school district or county team. When the parent and child report for assessment, information is communicated back to the ECS Coordinator.

For health concerns, the school nurse or county public health nurse may be the "case manager." The Learning Readiness program can also "case manage" several aspects of the referral because of the planning and service nature of that program.

In each case, the information about how the parent has taken the next step - and the results of that action - needs to be communicated back to a central person such as the ECS Coordinator. This is so the ECS follow-up is completed and the results of diagnosis/assessment and treatment or service can be recorded on the child's individual ECS record (on the ECS Summary sheet and/or in the Pupil Health Record).

To expedite follow-up, some ECS programs provide the parent with the referral form at the screening site, plus a stamped and addressed envelope for return of the information. If information is not returned, the first follow-up contact with parents should be within two weeks of the screening event. This contact provides opportunity to reinforce the explanations of findings to the parents and determine obstacle to seeking further evaluation or services. Ensuring that acceptable and accessible resources are available is essential. The next contact is determined by the nature of the problem - high risk situations or major medical problems take priority and require a second follow-up contact within another two or four weeks after the screening. If not a high priority, the second follow-up contact can be four weeks after the first, or six weeks after screening.

A follow-up worksheet is a way to list the children with noted potential problems, contacts with the family, and the results. The information on the worksheet can then be summarized to establish the population-based needs of the children in the community and also to measure the validity of the screening process. Information on the follow-up worksheet is just that, a worksheet. Actual information about the follow-up contracts and the referral results need to be recorded on the children's respective ECS Summary Report or in their Pupil Health Record which is the permanent record of screening and the results.

Notes on Completion of the Follow-up Worksheet. The worksheet on the following page corresponds to the ECS Annual Report of Potential Problems, Referrals and Results. (See Appendix F. for the form and for instructions that can also relate to the worksheet on the following page.) There are two types of referrals: the Potential Problems and the Risk Factors. Potential Problems are those with a

prescriptive course of diagnosis/assessment and treatment or service. Problems can be noted under the initials on the form of V- vision, H - health, D - developmental, G - growth, I- immunizations, H - health (determined from information from the health provider, the health history or physical assessment). The results can be recorded on the second section of the follow-up worksheet under the problems Confirmed and Resolution of Problems. The Risk Factors, on the other hand, are determined to be low, medium or high risk and include access to health care, early childhood experiences and family situations. Results of screening for the Risk Factors would be recorded under the Services for Risk Factors section of the second segment on the worksheet. Totals for each category of potential problems and risk factors, and then the results of screening can be reported on the ECS Annual Report.

Recall that the results of screening are in two categories: **output** - the number of children attending screening. But the real results, the impact of the screening program, is determined by the **outcome** - the problems noted, problems confirmed, and the children whose problems have been resolved or where the child is in a course of treatment or service.

[See also the discussion of data privacy and documentation in the last section of this chapter.]

ECS Referral for Potential Problems

Child's Name	Refer Date	Potential Problem +						Risk Factors				Follow-up Contacts					
		V	H	D	G	I	H	Health Coverage/ Access	Early Childhood lo med hi	Family Situation lo med hi	Other	#1 /date	#2 /date	mail /date	com- pleted /date	docu- ment /date	Notes

+ Vision, Hearing, Development, Growth, Immunization, Health

ECS Results of Referrals

Child's Name	Confirmed			Resolution of Problem			Services for Risk Factors								Notes
	No Problem	Confirmed Known/ New		Medical Inter- vention	Special Edu- cation	Other	Learning Readiness		Parenting		Head Start	Adult Literacy	Family/ Community Services	Other	
							Referred lo med hi	Participating lo med hi	ECFE	Other					

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C. SCREENING IMPLEMENTATION

1. ECS SCREENING MODELS

School districts have several options for providing the ECS program. The options depend on the resources of the school district and the availability of other agencies to participate in collaborative or contracted arrangements. The school district may contract with an approved Child and Teen Checkup agency, may contract with private health care providers or have local district personnel trained to conduct the screening. The school district may establish the program in cooperation with ECFE or other existing community programs.

Besides variations in the types of providers, school districts also have choices as to the number and types of components to offer. The decision to offer components beyond those required depends on the community's needs and values, and the skills and influence of ECS providers.

Contracting with other agencies or providers:

When a district arranges for another provider or volunteer program to do all or part of ECS, it is strongly recommended that a contract or written agreement be made. The Minnesota Department of Education cannot provide the legal service of offering a sample contract, but certain information should appear in a school district's contract with ECS providers:

- Clear identification of the persons providing the screening and the services to be offered, and a statement that all services will comply with ECS standards.
- A statement that all services are for screening only and do not include diagnosis or treatment.
- If services are delegated by qualified professionals, the school district must have a statement of assurance that a qualified professional will assume responsibility for delegated services and that adequate supervision will be provided.
- Assurance that exchange of information will be done in compliance with the Data Privacy Act.
- Procedures for submitting the results of screening to the school district.
- Terms for payment in full.
- Inclusive dates for the term of the contract.
- A cancellation clause for either party.
- Signatures of the Treasurer and the Clerk of the local school board, and authorized official for the ECS provider.

Considerations for non-school ECS providers:

In some communities the school district will contract with physicians, county public health agencies, or other health care providers for all or part of the screening program. When school districts contract with private practitioners or community

agencies, the following policies must be considered:

1. It should be clearly indicated in the outreach procedures when private practitioners or agencies will conduct all or part of the screening, and that upon the request of the parent the information will be forwarded to the family's private physician or health care agency.

2. Before a school district contracts with a private physician or medical clinic, the local medical society must be consulted. If there is no medical society, the remaining physicians in the community should be consulted about the contractual arrangement.

3. With written parental consent, the screening results must be provided to the local school district and the school district shall determine which material will become a part of the school records.

4. Private practitioners or agencies cannot be the repository for the ECS results, unless a parental release is obtained to allow them to maintain screening information in their records. The screening results should be shared with the child's primary physician and dentist, provided a parental release is obtained.

5. It is recommended that referrals to specific providers be made at the summary interview by an employee of the school district or public agency, except when the child is screened by his/her primary physician. Referrals made in this manner assure transfer of information to the school district and utilization of community resources, and may reduce the potential for conflicts of interest.

6. In the event that treatment is needed and a physician or dentist conducts the screening, the parent has the option of paying for subsequent treatment. **It should be made very clear to the parent that ECS is for screening only and that diagnosis or treatment and other optional services are still voluntary**. If parents choose to receive optional services, they must be clearly informed of any financial obligations.

7. Where health care providers conduct the physical inspection in a separate location, the results should be sent to the school prior to completion of the remaining components for the summary interview.

8. When non-school providers are used, they should not make self-referrals or provide diagnosis/treatment services unless they are the child's primary provider for those services.

Issues to Consider in Model Selection:

1. **Single screening site**. It is highly recommended that the child's entire screening be done at one time and at one site to integrate all screening results and obtain a total picture of the child's health and developmental status. This can be accomplished by utilizing school personnel and/or by contracting with other providers.

2. **Parent understanding of options and fees**. Parents need to understand which components the district is required to offer (and are state funded) and which

are optional. When fees are charged, the parent needs a clear explanation of the service and service provider, and that the components are optional.

3. **Parent understanding of mandatory requirement**. The parent needs to understand that screening is required prior to entrance in a public school kindergarten; however, the parent may meet this requirement by having a comparable screen at their health care provider. The parent may also submit a signed statement that the child has not been screened because of conscientiously held beliefs.

4. **Comprehensive screening**. Integration of a child's health and developmental status provides a complete picture, not a fragmented view, of a child's readiness for school. Parental guidance/health promotion may be more in depth if a comprehensive program is provided due to more time for interaction, more issues identified, and more opportunity for reinforcement of major concepts. These are arguments that can be used both for district administrators in determining the program delivery mode, and to encourage parents to participate in optional components.

5. **Interagency cooperation**. Local coordination, communication, and collaboration among programs and agencies is encouraged to promote ECS activities.

2. ECS PROGRAM ACTIVITIES

A. OUTREACH

Since ECS has become a requirement for entrance in Minnesota public school kindergarten, participation rates have climbed. In greater Minnesota, many school districts report 100% participation of 3 ½ - 4 year olds, one year prior to school entrance. In areas where mobility rates are high and it is difficult to reach families, the participation rates at age 3 ½ to 4 years is lower. Besides the regular schedule for screening, these latter school districts must plan to screen some children within 30 days of their entrance to kindergarten.

Requirements of Outreach:

Checklist for ECS Program - Section on Outreach [current 1994-95]

OUTREACH/NOTIFYING/PREPARING

_ Outreach: Inform each resident family with a child eligible to participate about availability of ECS and state's requirement that a child receive screening not later than 30 days after enrollment in kindergarten in a public school (MS 123.702,3).

_ Provide notice that a child need not submit to the school program if date and results of comparable screening are obtained from the public or private health provider (MS 123.702,1; 1b(a)).

_ Optional components: If providing the optional family factors components, provide clear written notice that the parent or guardian may decline to answer questions or provide information about family circumstances or other risk factors (MS 123.702,1b(a)).

_ From parent or guardian, obtain consent to
1) screen the child at the school (or contracted agency) program,
2) request information from health care provider if child has been seen in the 12 months preceding screening (MS 123.702,1b(b)),
3) disclose screening results to the school district (MS 123.704; MR 3530.3700) for kindergarten enrollment (MS 123.702,1a), Learning Readiness or any other program (MS 123.704).

_ Request from a child's health care provider the results of any laboratory test or physical examinations within the 12 months preceding screening (MS 123.702,1b(b)).

Considerations When Conducting Outreach:

- Personal contact has been shown to be the most effective means of encouraging participation. This could be ECFE staff describing ECS or a personal telephone call describing ECS and scheduling an appointment.
- Parents who have participated in ECS are excellent outreach workers; their recommendations are perceived as valid by other parents.
- It is speculated that those who are reluctant to participate in ECS are often at either end of the socio-economic spectrum. Care should be taken to avoid conclusions without evidence of needs

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or lack of needs, and/or access to or lack of access to other services for these families.

- It has been found effective to emphasize inviting the family to participate in a screening that looks at the child's growth and development rather than a mandatory screening to determine school readiness.

- Efforts for outreach can be coordinated with other early childhood programs.

Essential Content of Outreach Materials:

- Participation in screening is required for school entrance. (The term ***required*** is more acceptable to parents than the term ***mandatory***.) It needs to be clear to the parent that the child may participate in the school screening or in a comparable screening offered by a private or public health care provider.

- Children age 3½ - 4 years old are encouraged to participate.

- The required screening components are available at no cost to parents.

- Dates and times for screening, including provisions for working parents.

- Expected length of time for screening.

- Statement that parents are notified of identified problems and referred for evaluation.

- Detailed data are not released without parental consent. Summary information by component is required for school enrollment. (See Appendix D. for the ECS Summary form.)

- Children who have had a well child assessment in the previous 12 months cannot participate in the optional components of health history, physical inspection or laboratory tests. Information from the well child assessment is requested so it can be reviewed at the summary interview.

- ECS does not replace on-going health care by a health care provider, but rather ECS encourages participation in health maintenance visits.

Outreach Methods:

The census track, in school districts that maintain current information on all residents, is the logical first step in outreach. Letters can be mailed to all families with a child aged 3 - 4 years inviting them to participate in screening. An appointment date and time can be sent or the family can be asked to call to schedule a convenient screening time. Follow-up postcards or telephone calls can be made to families who do not respond. Also, reminder postcards or telephone calls just prior to the screening date are time-intensive but very effective in improving attendance at screening.

Radio announcements of varying lengths can be helpful in explaining ECS to the community and in reaching a broad group. It is also possible to target radio advertisements to specific populations (e.g., the Hmong radio station or local school news programs). (See Appendix C. for sample radio spots.)

Advertisements as well as articles that describe ECS can be included in community newspapers or local shopper newspapers. These are often delivered to every home in the community. Appealing graphics are helpful. Remember to include a telephone number for parents to call to schedule screening.

Local elementary newspapers and Early Childhood Family Education or Learning Readiness newsletters reach families with young children. Flyers can be sent home with elementary students asking families to call ECS to schedule an appointment for younger children in the family.

ECS programs have also used some creative techniques to inform families, such as including a notice in the utilities (electric/gas/water) bill or in the medical assistance or food stamp mailings. Other programs or agencies such as ECFE, local preschools, health care providers, libraries, and Head Start programs can help promote ECS by posting flyers or distributing materials.

Health fairs, school information fairs, or open houses are another good opportunity to provide information to the public. This may include an information booth and flyers to explain ECS. Perhaps a parent who has experienced the program can be present to respond to questions. Some parents may want to register their 3½ to 4 year old children for screening appointments at that time, so a schedule and appointment calendar should be available.

Religious/spiritual organizations or local businesses such as grocery stores or drug stores, the post office or the county court house are good places to post flyers or announcements. A tear-off flyer or brochure with a contact number that families can take home is convenient.

Word of mouth is the best advertisement of a service. As ECS programs continue to improve collaboration with other programs, and as families see the benefit of screening and the connections to other programs, word spreads throughout the community about ECS.

The outreach information needs to be comprehended by the parents of young children. This may pose the challenge of having to send information in languages other than English. In addition, the literacy skills of some parent needs to be considered. The ECS statute states that information must be provided to parents in a way they can understand.

CHECKLIST FOR COVER LETTER TO PARENTS

The initial letter to parents/guardians asking their child to participate in screening serves several purposes:

1. to be a welcome invitation to the school system,
2. to be a welcome invitation to screening,
3. to emphasize the importance of early screening, assessment, and intervention,
4. to notify parents of their responsibilities under current law to have their child screened, and
5. to provide information on legal rights on consent for services and for disclosure and use of data.
6. to provide the necessary materials needed for scheduling screening and preparing for screening
7. to provide positive parenting information and to market early childhood programs.

Here are some issues to consider when preparing the cover letter to parents for ECS:

Introduction:

Invite parent/guardian and child to screening
Purposes:
Identify factors that may interfere with the child's learning or growing including health, development and family issues
Introduce parents to resources/programs in the community, including Learning Readiness
Other_____
Target: 3½ to 4 year olds, a full year before they enter school

Requirement: by state law, children must be screened for enrollment in school

Required components:
Development: cognitive, social/emotional, motor, speech/language
Sensory: vision and hearing
Immunization review
Growth: height and weight
Other risk factors
Summary interview with the parent

Optional screening components: (school districts can charge for these services)
Health history/status and nutrition review
Physical assessment, laboratory work
Family factors interview using the Family Information Sheet

Services also provided at screening:
Developing a Learning Readiness plan
Information and resources for families and their children
Other_____

Options:
Participate in the school screening or a comparable screening at a public or private health care provider if the child's health records indicate that the comparable services have been completed.

Scheduling:

Procedure for getting an appointment
Average length of screening
Supports to make screening accessible: transportation, translator, other_____

B. SCREENING

1. Components and Screening Personnel

Checklist for ECS Program - Section on Procedures and Personnel [current for 1994-95]

COORDINATION/PLANNING - continued

__ **Determine procedures and personnel:**

__ Provide screening consistent with standards of the Minnesota Department of Health (MS 123.702,1b(b)). (MDH standards are consistent with Child and Teen Checkups (DHS administered federal program) and American Academy of Pediatric guidelines.)

__ Provide a screening program for children once before they enter school, targeting 3½ to 4-year-olds (MS 123.702,1). Reimbursement will be paid for children screened ages 3½ through school entrance.
Offer the program to all young children in the community - future enrollees in public, nonpublic and home schools; screening is mandatory for public school enrollees.

__ Provide the required screening components at no cost to parents (MR 3530.3100,1).

Required Components: (current for school year 1994-1995)

- Sensory screening:
  - -vision screening
  - -hearing screening
- Developmental screening
- Growth screening (height and weight measurement)
- Immunization review
- Identification of risk factors that may influence learning
- Summary interview with the parent about the child
  - -including a review of health problems from previous health assessments and
  - -including referral for health coverage/health care

Optional components: (current for school year 1994-95)

- Review of family circumstances that might affect development (known as Family Factors using the Family Information Sheet Interview Guide)
- Health History
- Nutrition assessment
- Physical assessment (including oral inspection and blood pressure measurement)
- Mental health screening - used only as a follow-up to identification of risk factors
- Laboratory tests
- Dental screening (oral inspection with physical assessment)
  - - dental referral and dental education
- Others as included in the school district plan

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The next page is the section from the Checklist for ECS Program that pertains to the required and optional components. The pages that follow are the ECS Program Requirements Matrix. The matrix includes the component listed with the respective standardized tool or clinical tools to be used in the screening, the area(s) of observation and the qualifications of ECS providers.

The required components for screening are found in Minnesota Statute 123.702, Subd. 1b(a); the optional components are in MS 123.702, Subd. 1b(d). The qualifications of screeners are found in Minnesota Rule MR 3530.3300 Subparts 1 to 11 and MS 123.702, Subd. 4. The respective citations can be found on the chart. (See Appendix A. for the full text of the statute and rule.)

The screening components are to be provided in a manner consistent with the standards of the Minnesota Department of Health. This includes the standardized tool or clinical tool used, personnel, and referral criteria and process. The guidelines for the screening components, forms needed, and sources for the forms are on the charts that follow the ECS Program Requirements Matrix.

Checklist for ECS Program - Section on Components [current for 1994-95]

REQUIRED COMPONENTS OF A DEVELOPMENTAL SCREENING PROGRAM (MS 123.702, 1b(a)).
These components must be offered to and provided for each child. State aid reimburses districts for the required components;
if the aid is insufficient, resources may be transferred from the general fund to the ECS fund (MS 123.7045).

__ Review consent for screening, release of information [and the option to decline to answer the questions regarding family circumstances or other risk factors if provided as an optional component (MS 123.702 1b(a)].
Again notify parents that the child need not submit to the school district screening program if the child's health records indicate to the school that the child received a comparable screening within 365 days prior to the school program (MS 123.702,1b(a)).

__ Developmental screening:
Identification of the fine and gross motor skills, speech and language, social-emotional, cognitive status of the child (MR 3530.3000,3; MDE and MDH standards). The procedures must include (MR 3530.3400,3):
__A. parent report of child's functioning history in skills development, emotional status and behavior status.
__B. tool/test: direct observation of the child's functioning using standardized developmental screening instruments with norms for the age range tested, written procedures for administration, scoring and interpretation.

__ Hearing screening or referral (MDH standards)
(history of hearing/ear problems; puretone audiometer; tym;panometry optional)

__ Vision screening or referral (MDH standards)
(history of vision/eye problems; external inspection, muscle balance, visual acuity [HOTV]).

__ Growth screening -- height and weight, graphed (MDH standards).

__ Immunization review and referral (MS 123.70; MDH standards).

__ Identification of risk factors that may influence learning (local school district determination).

__ Summary Interview with the parent about the child: (See also Referral)
__ Interview with parent about the child (MS 123.702,1b(a)) to share all information with the parent (MR 3530.3700).
__ Review information obtained from the health care provider concerning physical assessments and laboratory tests received prior to screening (MS 123.702,1b(b)).
__ Provide a record to the parent of the month/year and results of screening (MS 123.702,4a).
__ Refer for assessment, diagnosis, and treatment when potential needs identified (MS 123.702,1b(a); MS 123.702,2).
__ Provide information about the names and agencies or providers to possibly be used for evaluation or diagnosis (MR 3530.3000,8).

ADDITIONAL/OPTIONAL COMPONENTS
The school board may offer additional components (MS 123.702,1b(d)). State aid shall not be paid for these components. School districts may charge parents a fee for optional components (MR 3530.4310), access resources from other early childhood programs or the general fund or seek in-kind or direct funds from community public/private service agencies or volunteer groups.

__ Physical assessment and blood pressure, dental assessments (MDH standards)

__ Laboratory tests (MDH standards)

__ Health history and nutrition assessment (MDH standards)
(The MDH Health History form contains the following: health care provider and utilization, family members and family health history, birth and health history, current health status, health practices, behavior review, lead exposure risk, nutrition review, immunization review)

__ Review of any special family circumstances that might affect development. (MDE guidelines) Parent may decline to answer questions or provide information about family circumstances; declining does not prevent child from being enrolled if all other components are met. If parent is not able to read, the information must be conveyed in a different manner (MS 123.702,1b(a)).

(The Family Factors interview using the Family Information Sheet includes: Child Care and Education, Health Care, Family Resources and Needs.)

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ECS PROGRAM REQUIREMENTS MATRIX: Components and Personnel

Required Components

[Definitions and standards are to be consistent with the standards set by Minnesota Department of Health (MS 123.702 Subd. 1b(b)).] **MN Rule 3530.3300**

Component	Standardized or Clinical Tool	Area or Focus of Observation	Provider	Qualifications
Vision	- External inspection, including lids, lashes, surrounding area - HOTV Chart - Observation, alternative cover test, corneal light reflection	Eye health Visual Acuity Muscle Balance	Persons trained (Subp. 6)	Trained by MDH or equivalent program (Subp. 10)
Hearing	Puretone Audiometric screening	Deviations from the normal range of auditory acuity	Persons trained (Subp. 6)	Trained by MDH or equivalent program (Subp. 10)
Development	Parent report Direct observation using a standardized tool MN Rule 3530.3400 Subp. 3	Child's functioning history in skills development, emotional status, behavior status Cognition Fine motor skills Gross motor skills Speech and language Social-emotional development (MN Rule 3530.3000 Subp. 3; MN Rule 3530.3400 Subp. 3; MDH Standards)	Without supervision: Special education teacher School psychologist Kindergarten teacher Prekindergarten teacher Registered Nurse Licensed Physician With on-site supervision: (++) Clinic assistant Volunteer (Subp. 5 and MS 123.702 Subd. 4.)	Equivalent program (Professionals listed in Rule have equivalent training in their preparation programs. Specific training provided on request.) (Qualified professional may train volunteers and/or clinic assistants.) (Subp. 10)

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Physical Growth	Balanced scale Vertical measurement using a right angle object resting on child's head Graph on a standardized growth grid	Weight Height Relationship to population norms and to own history	With on-site supervision: (++) Clinic assistant Volunteer	
Immunization Review	Immunization Record Parent interview	Immunization status	Health professional or Other clinic personnel with health professional on site (Subp. 4)	
Identification of risk factors that influence learning +	Local school district determination	Risk factors are related to: - health/health resources - family stressors - early childhood experiences	Education professional Health professional	
Summary Interview	Discussion/Interview with parent about the child	- Relationship between health and developmental findings - Parent perceptions of identified concerns - Provide a record for the parent of the month/year and results of screening - Referral resources	Education professional Health professional	

+ In 1992 the legislature instituted the components of assessment of family circumstances that might affect development and identification of other risk factors. Family Factors, using the Family Information Sheet as an interview guide was designed to review both the family circumstances and other risk factors. In 1993 the Legislature determined that the family circumstances component was to be optional but kept the language related to identification of other risk factors. School districts may choose to continue to use the Family Factors and/or the Health History to fulfill the Identification of Risk Factors required component.

++ A volunteer may perform any of the screening components without supervision if the volunteer meets the qualifications. A qualified professional may delegate services to volunteers or clinic assistants provided that "all delegated services comply with the rules and adequate supervision is provided. The professional is responsible for services delegated and provided by other persons" (Subp. 3).

Individuals who conduct screening are either licensed as or who have training similar to a special education teachers, school psychologist, kindergarten teacher, school nurse, public health nurse, or physician [or early childhood educator]. (MS 123.704, Subd. 4.) Given this criteria, the school district determines whether supervised paraprofessionals and non-professional volunteers may conduct components that use standardized tools. Clinical tools/interviews must be conducted by professionals. (See Chapter IV. B. Screening Principles, Types of Screening Tools for a discussion of standardized and clinical tools.

Optional Components

MN Rule 3530.3300

Component	Standardized or Clinical Tool	Area or Focus of Observation	Provider	Qualifications
Health History	Individual interview with parent(s)	Past health status Present health status Immunization status Perinatal health Psychosocial health Health practices Family health information	Professional health screener: Licensed medical physician Registered Nurse Other health professionals with training (Subp. 4)	Training by MDH recommended
Nutrition	Assessment of food intake	Nutrition status and practices Compare to growth measurements and general development and behavior	Professional health screener	Training by MDH recommended or equivalent program
Family Factors (Review of Special Family Circumstances)	Individual interview with parent(s)	- Child Care and Education - Health Care - Family Resources and Needs	Education professional Health professional	Self study of Family Factors guide Knowledge of family systems Interviewing/counseling skills
Dental	Dental inspection - part of physical inspection Dental education	Obvious oral or dental abnormalities Information about fluorides, snacks, sealants, regular dental visits	Licensed dental hygienist Registered or certified dental assistant Registered Nurse Licensed dentist Licensed physician (Subp. 9)	Training by MDH or equivalent program

Physical Inspection	Unclothed physical inspection according to normal procedures • pulse, respiration, blood pressure • head, eyes, ears • nose, pharynx, neck • chest, heart, lugs • abdomen • spine • extremities, joints, muscle tone • skin	Present health and developmental status (*) • normal aspects of health and development • new and/or known problems of health and development	Professional health screener: Licensed medical physician Registered Nurse Other health professionals with training (Subp. 4)	Training recommended Successful completion of training by MDH
Laboratory Tests	Urine (bililabstix) Microhematocrit, hemoglobin Blood lead test when history indicates the possibility of exposure to undue levels of lead in the environment or atmosphere. Sickle cell test when indicated by health history or physical inspection, only with specific consent of the parent. (*) Recommendations, not stated in Rule	Blood cells or albumin in the urine Anemia Increase lead absorption and lead poisoning Sickle cell trait or anemia	Persons trained. (Subp. 7)	Training by MDH or equivalent program
Other	As explained in school district plan			

ECS SCREENING COMPONENT GUIDELINES, EQUIPMENT, FORMS, SOURCES

Component	Component Guidelines	Equipment	Forms and Forms Sources
Outreach Access past health records Registration			*ECS Physician Request for Information* *ECS Parent Consent* *ECS Information Collection, Use & Consent* Samples from MDH; district makes copies. Library: Forms Minnesota Department of Health 717 Delaware Street SE, PO Box 9441 Minneapolis, MN 55440 Forms line tape recording: 612-623-5274
Sensory Screening: Vision	Early Childhood and School Age Vision Screening Manual, MDH, 1992.	Vision Screening Equipment: occluder penlight toy ½ inch in size as a target object HOTV responses panel and conditioning flashcard VOTHOV Vision Strip - [from MDH Screening Unit]	*Vision Screening Worksheet* Sample from MDH; district makes copies.
Hearing	Pre-school and School Hearing Screening Manual, MDH, 1985; Tympanometry in the Hearing Screening Process, MDH, 1991. Training for screeners and training for professionals supervising screeners provided by Hearing and Vision Conservation Unit, Minnesota Department of Health, 612-623-5288	Hearing Screening Equipment: audiometer toy (for conditioning) Optional Hearing Screening Equipment: tympanometer otoscope	*Hearing Screening Worksheet* Sample from MDH; district makes copies. Library: Forms Minnesota Department of Health 717 Delaware Street SE, PO Box 9441 Minneapolis, MN 55440 Forms line tape recording: 612-623-5274

Developmental Screening	Instruction manual for the developmental screening tool. Developmental Screening Overview: A Self Instructional Program for Nurses (from MDH Screening Unit] Training for Denver II by Child Health Screening Unit, Minnesota Department of Health, 612-623-5342	As specified by the developmental tool	*Developmental screening report* from selected developmental tool *Parent report of development* from developmental tool or Sections of the *Health History* (see Health History section below) See end of this section for addresses of commonly used Developmental Tools.
Growth: Height Weight	In Nutritional Screening of Children, A Manual for Screening and Follow-up (US DHHS Pub.No. (HSA)81-5114). Nutrition Section, Minnesota Department of Health, 612-623-5000	Height Measurement Equipment: Metal measuring tape or yard stick mounted on wall that has no baseboard, block squared at right angle Weight Measurement Equipment: Balance beam scale, weight for standardizing scale Ruler for graphing height and weight	*Growth Chart for boys/girls for 2 - 18 years* Ross Laboratories Department L-1120 Columbus, OH 43260 1-800-227-5767
Immunization Review	Recommended Schedule of Active Immunization of Infants and Children, annual revisions Immunization Unit, Minnesota Department of Health, 612-623-5237		*Minnesota Immunization Record Card* or Section of the *Health History* Variety of information brochures: Immunization Unit Minnesota Department of Health P.O. Box 9441 Mpls., MN 55440 612-623-5237

Health History [optional]	Professional trained in history taking by MDH or equivalent program; Early Childhood Health and Developmental Screening/Early and Periodic Screening Training and Screening Manual, revised 1994 provided with training through Child Health Screening Unit, Minnesota Department of Health, 612-623-5286		*Health History*, latest revision Sample from MDH; district makes copies. Library: Forms Minnesota Department of Health 717 Delaware Street SE, PO Box 9441 Minneapolis, MN 55440 Forms line - leave message on recording: 612-623-5274
Mental Health Checklist - use only as a follow-up to findings in other components [optional - follow-up only]	Guidelines for Early Identification of Mental Health Needs in Children and Youth, 9/91 Child Health Screening Unit, Minnesota Department of Health, 612-623-5286		Forms in Guidelines... for Mental Health; use only as a follow-up to findings in the Health History, Family Factors, Developmental Screening and/or Summary Interview
Family Factors [optional]	Early Childhood Screening : Family Factors Guidelines (Catalog #E1103), MDE, 1993; $2.50 in Minnesota Note: When the Guidelines were written, Family Factors was a required component of ECS. Forms and interview remarks need to be modified to reflect that this is now an optional ECS component. Minnesota Educational Services Capitol View Center 70 West Co. Rd. B2 Little Canada, MN 55117-1402 1-612-483-4442; 1-800-652-9024		*Family Information Sheet* (1993 or later) or *Family Information Sheet - Addition to Health History* or *Combined Health History and Family Information Sheet* Revised form that reflects Family Factors as an optional component available from MDE; School district makes copies. Early Childhood Screening Program, Minnesota Department of Education. 550 Cedar Street St. Paul, MN 55101

Health Coverage and Access to Health Care	Referral information for Minnesota Care, 1-800-627-3672; 612-297-3862 Local referral sources		*Health History* or *Family Factors*
Physical Inspection [optional] Laboratory Tests [optional]	Physical Examination: A Self-Instructional Program for Nurses Professional health care provider trained by MDH or comparable training: Training Manual Training is a part of the C&TC program - not offered separately. Child Health Screening Unit, Minnesota Department of Health, 612-623-5342	As needed for physical assessment As needed for laboratory tests	Physical Assessment record from MDH training manual *Laboratory Analysis/Request Form* Sample from MDH; district makes copies. Library: Forms Minnesota Department of Health 717 Delaware Street SE, PO Box 9441 Minneapolis, MN 55440 Forms line - leave request on recording: 612-623-5274
Dental Inspection and Referral [optional]	Professional trained in dental inspection by MDH or comparable training: Training is a part of the C&TC program - not offered separately. Child Health Screening Unit, Minnesota Department of Health, 612-623-5342		
Nutrition Assessment [optional]	Professional trained in nutrition assessment by MDH or comparable training: Training is a part of the C&TC program - not offered separately. Child Health Screening Unit, Minnesota Department of Health, 612-623-5342		*Health History* - Food Frequency section

Summary Interview	Included in the training for health professionals in the training manual by Child Health Screening Unit, Minnesota Department of Health, 612-623-5286 See also ECS: Family Factors Guidelines, pp. 3 - 7; 42-43.		*Summary, ECS* (dated 6-93 or later) Sample in Appendix D or from MDE; School district makes copies. School district may create Summary Form if all elements of the MDE sample are included. Early Childhood Screening Minnesota Department of Education 550 Cedar Street St. Paul, MN 55101 *ECS Information Collection, Use and Release Consent;* *ECS Survey for Parents* Sample from MDH; district makes copies. Library: Forms Minnesota Department of Health 717 Delaware Street SE Minneapolis, MN 55440 Forms line - leave request on recording: 612-623-5274 *Pupil Health Record* Booth Documents & Publishers Co. P.O. Box 519 716 Main St. North Branch, MN 55056 1-800-245-5835; 612-674-4413
Referral and Follow-up			

Listed below are the sources for commonly used developmental screening tools. This is not an inclusive list of all tools available.

ESP - Early Screening Profiles	AGS - American Guidance Service, 4201 Woodland Road, PO Box 99, Circle Pines, MN 55014-1796; 1-800-328-2560
Denver II (formerly the DDST), revised 1993	DDM INC., PO Box 6919, Denver, CO 80206-0919; 303-355-4729
DIAL R - AGS Revision	AGS - American Guidance Service, 4201 Woodland Road, PO Box 99, Circle Pines, MN 55014-1796; 1-800-328-2560
MPSI, Mpls Preschool Screening Instrument	Minneapolis Public Schools, 807 NE Broadway, Minneapolis, MN 55413
PDI, Preschool Development Inventory	Behavioral Science Systems, Inc., Box 580274, Minneapolis, MN 55458; 612-929-6220 (parent interview; use with an observational tool)

Health Components. A core health component of screening - the Health History - is an optional component. Therefore, the question has been raised as to what health components are required as a part of screening. First, the school district must request information from a health care provider that the child has been seen for a well-child check-up in the 12 months prior to screening. Secondly, an inquiry must be made at screening as to the availability of health care coverage and access to a health care providers. Thirdly, the vision and hearing screening components include questions to the parent about the past eye health and about a history of ear problems/infections. The parent report of development may raise health issues such as a history of accidents or other signs of potential neurological problems, questions about feeding and nutrition, speech problems related to hearing problems and ear infections, or other health issues. Finally, the immunization review often raises questions about allergies to immunizations, changes in available immunizations, or changes in the requirements for immunizations.

Physical Examination for School Entrance. Physical examinations are not required by state law. The ECS statute says that if a child has had a physical, health history, or lab work in the 12 months prior to screening, the school district must request the results. This is so that medical/health findings can be integrated with information from other components for a view of the whole child. **If a child does not have health coverage, the ECS program must refer the child to a health care provider (presumably for a physical assessment and well child check) but the parent is not required to take the child for this service**. If a child does have health coverage and a health care provider, a well child visit is to be recommended; but again, the parent is not required to take the child for care.

2. **Personnel**

Checklist for ECS Program - Section on Personnel [current 1994-95]

COORDINATION/PLANNING - continued

__ Determine screening personnel/program staff: (MS 123.702,4; MR 3530.3000,10;3530.3300)

__ Designate a coordinator (MR 3530.3300,1)
__ Select individuals to conduct screening who are either licensed as or who have training that is similar to a special education teacher, school psychologist, kindergarten teacher, prekindergarten teacher, school nurse, public health nurse, registered nurse or physician (MS 123.702,4) or early childhood family educator.
__ Determine the relationship between professional staff and clinic assistants:
__Training must be provided (MR 3530.3300,6,7,8).
__The professional must assure the standards are maintained; the professional is responsible for the services provided by other persons such as clinic assistants (MR 3530.3300,2).
__On site supervision is required (MR 3530.3300,2 & 8).
__ Train staff and/or annually review procedure guidelines for each component (MR 3530.3300).
__ Utilize volunteers in implementing the program to reduce the costs of screening (MS 123.702,1 & 4); integrate and utilize a volunteer screening program whenever possible (MS 123.702,5); give first priority to qualified volunteers (MS 123. 702,7; MR 3530.3300,2).
__ Second priority shall be given to those who posses minumum qualifications and who can provide services determined to be most cost effecive (MR 3530.3300,2)

School Administrators and School Board Members:

All successful school-based programs use the support of administrators and school board members who make decisions related to the communities' needs and resources within the parameters of established law and rules. The superintendent or authorized agent:

- is informed of changes in the ECS legislation at the close of the legislative session by the Commissioner of Education.
- with the ECS Coordinator submits an annual plan to the school board for approval; records school board action regarding ECS plan approval.
- ensures delivery of ECS according to the law, rules, and other statements of assurance on the ECS completion report.
- certifies information on the ECS completion report and request for reimbursement.
- receives an annual evaluation report from the ECS Coordinator.

ECS Coordinator:

"Each district shall designate an Early Childhood Screening Coordinator to be responsible for administering all components of the screening program. The coordinator may be a volunteer" (MR 3530.3000 subp.1). Each school district's designated ECS Coordinator manages the overall screening program and organizes the screening clinic activities.

The ECS Coordinator must be a licensed professional in an education or health program. He/she should have organizational and management skills. Experience with child health and early childhood education programs, as well as with screening programs, is highly desirable. The judgement, authority, and responsibility required for program planning, implementation, and evaluation require the knowledge and skills of a professional. This professional must also have ready access to and support of the school district administrators and school board members. Professional judgement and decisions are required for the policy issues to be addressed as described in the planning phase of the program as outlined in the sections in Chapter II and Chapter III. Implementation of the program requires supervision of professional staff, paraprofessionals staff, and volunteers. The evaluation process requires skills in data collection, analysis, and program redesign. The role of support staff to the program cannot be underestimated, as there is a great deal of preparing and tracking correct information and detailed communication that is required. The support staff are critical to ensuring the timely and accurate notice to parents, enrolling children in screening, preparing for and supporting the screening process, and assisting with obtaining follow-up information.

The ECS Coordinator:

- Annually plans the program by setting goals based on an evaluation of the previous year's program and incorporating changing community needs, values, and resources.

- With the superintendent submits the plan to the school board for annual approval.
- Arranges for and conducts outreach.
- Recruits, orients, schedules, and supervises screening personnel including professionals and volunteers; plans initial training and annual review for all screening providers.
- Arranges physical facility for screening sites; assembles equipment and supplies needed at the clinic site; coordinates the setting up and dismantling of the clinic site.
- Supervises clinic functions; receives and provides comment on program efficiency and quality.
- Monitors follow-up, documentation, and communication of ECS findings and data.
- Evaluates the structure, process, and outcome of ECS; participates in statewide evaluation efforts.
- Reports to the superintendent and school board the ECS data results of the evaluation and plans for improvement; reports to ECS team members, the public, state legislators, and administration; submits the completion report and request for reimbursement to Minnesota Department of Education.
- Shares program successes and failures with other ECS Coordinators in the county and/or region and with state staff for the purpose of improving the program statewide.

Professional Screeners:

Screening personnel are "professional, paraprofessional and volunteer staff who conduct activities as part of the screening program" (MN Rule 3530.3000 sub. 10).

Authority and Responsibility of Professional Screeners. When participation in screening became a requirement for school enrollment in 1992, the Legislature determined that professionals needed to conduct most components of the program, particularly the developmental component. It was then decided that parents and children needed the best advice available, especially because participation in the program is required. In 1993, the language was changed to "persons trained similar to [professionals listed in statute]" so that school districts would have some flexibility in staffing programs in a cost effective manner. But the principle stands, that the best service available should be provided. As discussed in the next sections, whether paraprofessional staff or volunteers participate in screening, the professional staff are still responsible for the actions of the paraprofessionals - for training and supervising the paraprofessionals, and for rescreening children found with potential problems prior to referral.

Multidisciplinary/Interdisciplinary Nature of ECS. The experts from different but related fields have the opportunity to come together at ECS and share their expertise with parents and with each other. There is benefit in early childhood specialists, health specialists, and elementary educators sharing their knowledge, skills in screening and assessment of children, and viewing the needs of children from differing perspectives. In this way, the unique

contributions of each discipline to the screening effort can be more fully respected and appreciated.

Professional Health Screeners. A core health component of screening - the Health History - is an optional component. Therefore, the question has been raised as to whether or not professional health screeners - specifically school nurses or county public health nurses - need to be present at the screening. Yes, an ECS program must have a professional nurse on site. Even without a required Health History component, nursing expertise is required for other screening components. At a minimum, nurses need to be on site to offer staff and parents advice on health and medical issues. If a child has any abnormal findings on information returned by a physician or health clinic, the nurse needs to interpret the findings and determine the relevance of the health issue to the child's development and learning. Providing advice regarding changing immunizations is another role. Training and supervising paraprofessionals for vision or hearing screening is a necessity, as well as rescreening children identified as having potential sensory problems. The professional nurse can make the referral so that it is valid, timely, and cost effective for the parent and for the school.

Volunteers:

"In selecting personnel for screening programs, school districts shall give first priority to volunteers who have the qualifications required" (MN Rule 3530.3300 sub.2). "A volunteer may be a lay person, paraprofessional, or professional who performs screening without fee or payment" (sub. 11).

When recruiting volunteers, having educational experience with young children is desirable.

Volunteers may:

- Assist ECS coordinator with outreach efforts.
- Welcome and guide families through the screening process.
- Conduct vision and hearing screening when annually trained and supervised on site by a health professional.
- Conduct developmental screening if the volunteer is "an individual who is licensed as or has training that is similar to a special education teacher, school psychologist, kindergarten teacher, prekindergarten teacher, school nurse, public health nurse, registered nurse or physician" (MS 123.702 subd.4).
- Supervise play area.
- Measure height and weight and record on growth charts when trained and supervised.
- Assist clerical staff.
- Perform any screening component for which they have the qualifications specified in Rule.

Clinic Assistants:

"A clinic assistant is a lay person or paraprofessional who may perform any component of the screening program. A clinic assistant must be under the supervision of a professional qualified for the screening component for which the

clinic assistant is used. The professional must be present at the screening site" (MN Rule 3530.3300 sub. 8). Clinic assistants are paid screening staff whereas volunteers are not.

Individuals who conduct health and developmental screening are either licensed as or have training similar to a special education teacher, school psychologist, kindergarten teacher, school nurse, public health nurse, or physician [or early childhood educator]. (MS 123.704, Subd. 4.) The language of the statute does not specifically state that paraprofessionals can be screeners. Given the language in statute, each school district must determine whether supervised paraprofessionals and non-professional volunteers can be screeners and meet the standard of being "trained similar to... [professionals listed in statute]." Language in MR 3530.3300, Sub. 8 defines the clinic assistant as stated in the above paragraph and includes the stipulation that the clinic assistant be supervised on site. The professional is responsible for the screening conducted by the paraprofessional.

All children screened for a given component by non-professionals with results that need referral should be rescreened by the professional prior to referral. Paraprofessionals or nonprofessional volunteers may conduct ECS components that use only **standardized tools**. ECS components that require **clinical tools/interviews** must be conducted only by professionals. [See Chapter IV, Screening Principles.]

Delegation of Responsibility: Provisions for delegation of responsibility for screening services are the same whether the delegates are volunteers or clinic assistants. "If a qualified professional delegates services, the professional must assure that all delegated services comply with (the ECS Rules) and that adequate supervision is provided. The professional is responsible for services delegated and provided by other persons" (MN Rule 3530.3300 sub.3).

C. REFERRAL and FOLLOW-UP

Checklist for ECS Program - Section on Referral and Follow-up [current for 1994-95]

REFERRAL AND FOLLOW-UP

_ Ensure that an appropriate referral process is available (MS 123.702,2).
Three types of referrals are to be made: when there is a potential need or condition that requires further assessment; when the family lacks health care coverage; and referral to programs or services that maintain and enhance health and development. The first two types of referrals require follow-up contacts.

_ Notify the child's parents of a potential need or condition that requires assessment, diagnosis or treatment (MS 123.702,1b(a);2); all information must be made available to the parent (MR 3530.3700). Provide information about the names, agencies and providers to possibly be used for evaluation or diagnosis (MR 3530.3000,8). Referral criteria are included in the standards set by MDH or in the developmental screening instrument selected by the district.

_ If a child is without health coverage, refer the child to an appropriate health care provider (MS 123.702,1b(c)); include discussion of Children and Teen Checkups through Minnesota Care, Medical Assistance or other source of insurance and/or services.

_ Make referrals to programs and services that support the health and development of the child even when there is no identified problem. Health maintenance referrals are for periodic medical or dental examinations, immunizations or health or nutritional counseling (MR 3530.3000,4) and are to encourage parents to keep children connected with a health/medical "home" and receiving periodic well child care. Referrals may be made to Early Childhood Family Education and other early childhood programs in the community that enhance the child and family's growth and development. No follow-up contacts are necessary for these types of health maintenance and child development-enhancement referrals.

_ Diagnosis, treatment or therapy are not to be provided as a part of ECS although may be provided through other programs (MR 3530.4200).

_ Special education placement decisions, diagnostic conclusions and objectives for individualized education plans may not be based solely or primarily on screening data (MR 3530.4300).

_ Screening findings may be utilized in the first stage of development of the individualized service plan in the Learning Readiness initiative (MS 121.831,2;4(1)).

_ Screening findings may be utilized as one indicator in determining risk for the Early Childhood Family Education Home Visiting program (MS 121.882,2b(b)(1)).

_ Ensure that an appropriate follow-up process is available (MS 123.702,2).

_ The Learning Readiness program is a potential avenue for follow-up as listed in its program characteristics (MS 121.831, Subd. 4 - 1,4 & 6).

A screening program has three stages: outreach, application of tools or measurements at a scheduled screening event, and follow-up. Without follow-up, the benefit of screening is questionable. Coordinators of screening programs are challenged to put as much time, energy, and resources into follow-up as the other stages of a screening program.

At screening three types of referrals are to be made: 1) a) when there is a potential need or condition that requires further assessment, b) for linkages to programs when risk factors are identified, 2) when the family lacks health care coverage, and 3) referral to programs or services that enhance health and development. The first two types of referrals require follow-up contacts; the third does not require follow-up.

Referral

Referral is a process of determining whether or not information noted at screening requires assessment by another source. Referral involves the synthesis of at least five sets of information: 1) specific findings from the standardized tool or from

the clinic interview tool, 2) synthesis of the findings from one component with all other findings, 3) knowledge and perceptions of the professional screeners and the professional conducting the summary interview, 4) perception of needs and wants of the parent, and 5) experience, capacity and skills of the parent in dealing with health/developmental issues, and skills in problem solving family crisis.

The likelihood that the parent will take steps for further assessment of a problem identified at screening is dependent on the degree to which the parent understands and agrees with the problem noted at screening. Therefore, the summary interview and referral process can begin with the parent's perception of the findings and screening and any awareness he/she may have of a noted problem. Then the summary interviewer can relay information of potential problems and discuss the findings.

A second factor influencing the likelihood of a parent acting on a referral is the experience with and methods used in solving problems. Therefore, part of the summary interview is assessing the approach used by the parents, and matching the referral steps that need to be taken with this approach. [See Chapter IV. Concepts: Problem Solving.]

The skillful summary interviewer assists the parents in determining which steps need to be taken in a logical order. For instance, for the child with a problem noted on the hearing screening, a history of ear infections, and a speech problem as noted in the developmental tool component, the first step is a medical referral for diagnosis and treatment of an ear infection. Only then should a follow-up speech assessment be scheduled.

A third factor involves the number of problems and the severity of problems noted at screening. The parent and summary interviewer decide together which problems are high priority for immediate action. Criteria for determining if a problem requires immediate action include whether there is imminent danger or potential for harm to the child and if there is a legal mandate to refer, such as for suspected child abuse or neglect. Any acute health problem that may cause the child pain or future harm is high priority such as an acute ear infection, signs of neurological problems indicated by the developmental findings, sensory screening findings in combination with the parent's perceptions. Next are sensory problems because the eyes and ears are gateways to all information, and any problems with sight or visual perception or hearing must be addressed before other assessments for conditions that would require accurate vision and hearing. Again, while the parent and summary interviewer decide together which problems are highest priority, the summary interviewer may provide information in such a way that the parent understands more clearly why one problem may warrant earlier attention than another problem.

In some cases, the number of issues raised at screening may prove to be overwhelming for the parent. Or for other reasons, the information cannot be reviewed thoroughly. Or the parent may not be able to decide on the next appropriate actions. In these cases, the summary interview is best handled by making an appointment for a longer time to review the issues. This summary interview appointment should be within a couple of days of the ECS. Appropriate referrals to community agencies or organizations should be made at this time.

Decisions for Referrals

1. Previously known problems have resurfaced or a child's case or service has lapsed.

2. Potential concerns related to a child's development or health are found using specific measurable criteria obtained from the standardized screening instruments or interviewing tools. A relatively clear course of further assessment, diagnosis, intervention, or treatment can be planned so concern is solved or remediated.

3. Identification of family factors which may affect a child's health or development, such as family support needs, social service needs, housing, parental literacy, or lack of access to early childhood programs. The referral is less prescribed and is determined primarily by the parent and available community resources. [See the cube diagram on page 9 for an illustration of low, moderate, and high risk.]

4. Specific identified problem requiring follow-up.

5. General health maintenance activities to enhance child and family development do not require follow-up (e.g., next scheduled immunization, 5-year old well child check-up, an ECFE parent and child classes).

[See also the discussion on referral categories in Chapter II. ECS Report of Potential Problems, Referrals and Results.] [For more information on interviewing family members and on synthesis of findings and referral, see the ECS: Family Factors Guidelines, pages 3-7, 42-43.]

Follow-up: Confirming Findings

One of the basic concepts of any screening program is that **the program is not complete until the follow-up is complete**. One-third of the time in a screening program goes into outreach, one-third goes into screening and one-third into follow-up. Follow-up includes ensuring that: a) children with identified potential problems get an assessment that confirms or denies the existence of that problem and b) the children who then need a course of treatment or service to resolve the problem are, in fact, enrolled or receiving service as planned.

Follow-up consists of contacting the parent at least twice to find out if the problem noted was or was not confirmed, if there is a course of treatment or intervention being followed for remediation and if the referral source was acceptable and accessible. Good practice dictates that there be at least one attempt by mail with return postage if the parent cannot be reached by telephone. Follow-up contacts can be recorded on a worksheet; then pertinent information is to be transferred to the permanent ECS record, such as the follow-up section on the ECS Summary sheet or in the Pupil Health Record. Referrals for health maintenance visits, when no problem has been identified but routine preventive visits to health providers have lapsed, is not required. [See also Chapter III. B. Evaluating.]

There are two benefits to completing follow-up. First, children can begin a course of treatment or services to resolve or deal with the identified problems or concerns. Second, By summing the true positives and false positives for all the children screened and referred by

component, the benefit of the screening for each component can be judged. This is a measure of the accuracy of the screening instruments and of the screening procedures. Each screening component needs to be refined based on these data. (See Chapter IV. Concepts Core to ECS - Screening Principles.)

Once the referral information is returned, the following conclusions can be drawn:

1. **true positive**-if a potential problem identified at screening is confirmed by assessment or diagnosis

2. **false positive**-if a potential problem identified at screening, upon further assessment, has been found to be normal.

For the health and developmental components at ECS, through the use of standardized tools or clinical tools, the screening findings are categorized as "OK" or "needs referral" (formerly called "pass"/"fail"). Those identified as "OK" means the criteria have been met so that the child has no potential problem, falls within the normal range of findings for the instrument used, and the parent and/or screener have no other historical or observational information to consider that would modify that screening finding. "OK" means no potential problem is identified.

For the finding "needs referral," the results from using the standardized tool and/or the clinical interview have indicated the child does not fall within the normal range of findings for his/her age. The call of "needs referral" is based on three factors: the results of the standardized tool, interview information from the parent, and the clinical judgement of the screener. Old rhetoric used the term "failed" for this finding, but this is inappropriate for any component of screening, especially in an early childhood setting where the child and the parent are very attuned to judgmental terms and labels.

In the follow-up contacts with parents, ECS staff:

- ensure parents understand the nature of the ECS findings and the need for referral. All information must be made available to parents.

- affirm that sources for further evaluation and diagnosis and for programming and treatment services are appropriate to the problem and are both acceptable and accessible to the family.

- advocate for families who are having difficulty accessing the services of the health care system and/or the educational system in a timely manner and to the extent necessary to meet the child's needs.

- reinforce the family's problem solving skills by reviewing steps already taken to seek further evaluation and necessary services. Assist family to identify subsequent actions.

- reinforce health promotion/parental guidance information provided at ECS.

- include discussion about Child and Teen checkups through Minnesota Care or Medical Assistance, other sources of insurance, and referral to an appropriate health care provider, if the child is without health coverage..

Staff of the Learning Readiness program (M.S. 121.831, 4(6) can assist with the

follow-up process and can further provide services to children and families as determined through the referral/assessment process. Screening results can be utilized in the first stage of development of the individual service plan in the Learning Readiness Initiative (MS 121.831,2:4(1) and as an indicator in determining risk for the ECFE Home Visiting program MS 121.882, 2b(b)(1).

Follow-up: Documentation and Communication

The second aspect of follow-up is documentation and communication of concerns. With the consent of the parent, a summary of ECS data is to be incorporated into the school records and the Pupil Health Record (Appendix E). Educational team members need information, both the strengths and limitations, about students so they can make adaptations in the educational programs and/or the environment to meet the needs of students. ECS follow-up is complete when relevant data has been communicated to and interpreted for kindergarten teachers and the school nurse has received ECS reports. [See the next section on data management.]

D. DATA, RECORDS, REPORTING

Checklist for ECS Program - Section on Data and Records [current 1994-95]

DATA/RECORDS

—	Provide the parent/guardian with a record of month and year the child received screening and of the results (MS 123.702,4a).
—	Obtain parent consent to disclose screening results to the school district (MS 123.704) for kindergarten enrollment (MS 123.702,1a).
—	The school district shall keep a duplicate copy of the record of each child screened (MS 123.702,4a) and information shall be incorporated into the school district record (MR 3530.3800), in the cumulative record or the pupil health record which is a part of the cumulative file. The summary report is to be kept as a permanent part of the record; detailed forms and information can be returned to the parent. Screening data not substantiated may not be part of school records as confirmed health/developmental problems (MR 3530.3800).
—	Establish a system for the school principal (or designee) to receive a record indicating the month/year screened and results (MS 123.702,1a). The record may be of ECS or a comparable screen by a health care provider (MS 123.702,1).
—	Send/receive records of children who transfer during kindergarten; allow 30 days for parent/guardian to submit records (MS 123.702,1a) during which time a child may attend school (MS 123.702,1a).
—	Annually submit a report summarizing the program and a request for aid payment (MR 3530.3200,6).

Data on Individual Children

Data privacy is a right of students in Minnesota schools. Appropriate handling of individual health and education data on children begins at Early Childhood Screening. While some parents and ECS staff may view signing the forms for consent for release of information as more paperwork; however, a constent form is a significant tool to protect the legal rights of the student and family. It is helpful to explain this to parents and staff. The Minnesota Government Data Practices Act ensures that whenever a governmental agency asks for private or confidential information, the individual must be told:

1. why the data are being collected,
2. how the data will be used by the collecting agency,
3. whether the individual can refuse or is legally required to provide the data,
4. what the consequences are to the individual if the data are supplied or if the individual refuses, and
5. the identity of other persons or entities that are authorized to receive the data.

See a summary of federal and state laws regarding data privacy and records in Appendix E.

Key steps to take regarding ECS data on individual children include:

1. Provide parents with a record of month and year of screening and other results by component. Obtain parent consent to disclose detailed screening results to the school district or any other agency (See the statute, MS 123.704, in Appendix A) The date and results of screening are required for school entrance. If a parent would prefer that certain sensitive

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information, such as a summary of findings from the family information sheet, not be recorded, a statement such as "no summary statement at parent's request" could suffice.

2. The school district shall keep a duplicate copy of the record of each child screened (MS 123.702. Subd. 4a) and information shall be incorporated into the school district record (MR 3530.3800).

3. The ECS Summary Form becomes a part of the student health record, and therefore a permanent part of the cumulative file. It is not necessary to keep the entire health history form or Family Information Sheet (Family Factors interview form). Pertinent data can be summarized on the ECS Summary form, and then the detailed records returned to the parent, even at the time of screening if the summary is complete. Or the detailed health history and Family Information Sheet can be returned to the parent at the time of the parent-teacher conference after the kindergarten teacher has reviewed the information. Information not returned to the parent which is purged from the cumulative file must be shredded or burned because it contains private data. In cases where the data provide an important baseline for further assessment of a problem such as a chronic health problem or special education, forms may be retained in school records with parental permission as long as relevant..

4. ECS data are student health data, and therefore educational data. School districts need local policies concerning management of school records, including ECS information and pupil health records.

Summary Data: Reporting the Program, Problems, Progress

The worksheets used for follow-up can be the tool to collect summary data on the children served in the ECS program. The number screened compared to the number found with potential problems is reported as the yield. The number of those referred for potential problems whose problems are confirmed in a health or educational assessment/diagnosis is reported as the true positives - one measure of the accuracy of the program and benefit of the program. [For discussions of output and outcome summary data, see the ECS PER Tool (Chapter III), the discussion on follow-up as related to the annual state report on ECS Report of Potential Problems, Referrals and Results (Chapter II and Appendix F); and the Screening Principles (see Chapter IV).]

State Report. See Chapter II & Appendix F.

Local Reporting. The audience, method, and content of local reporting is determined by the community's communication methods, process of decision making, extent to which the public provides comment, and direction to programs and many other factors.

What to report: The ECS PER Tool guidelines suggest that reports include:

- Program goals
- Data as appropriate:
  Critical ECS data include:
  - number and types of problems identified

- number and types of problems confirmed
- profile of school enterers
- parental questions, expressed needs
- comments from parents, providers and referral sources

- Results of the evaluation

- Plans for change and improvement

Report to whom: ECS depends on collaboration among educators, health care providers, volunteers, and parents. One way to maintain the interest and involvement of collaborators is to provide evidence of their efforts and request feedback. The program also depends on the continued support of local and state decision makers.

The chart on the following page lists the potential recipients of ECS reports and the rationale for reporting. It can assist coordinators in making decisions about the dissemination of information about the local program. Here is a written summary of the ideas pictured:

ECS offers an opportunity for positive public relations for the school on the part of **parents** and this can be maintained through periodic reports to the public.

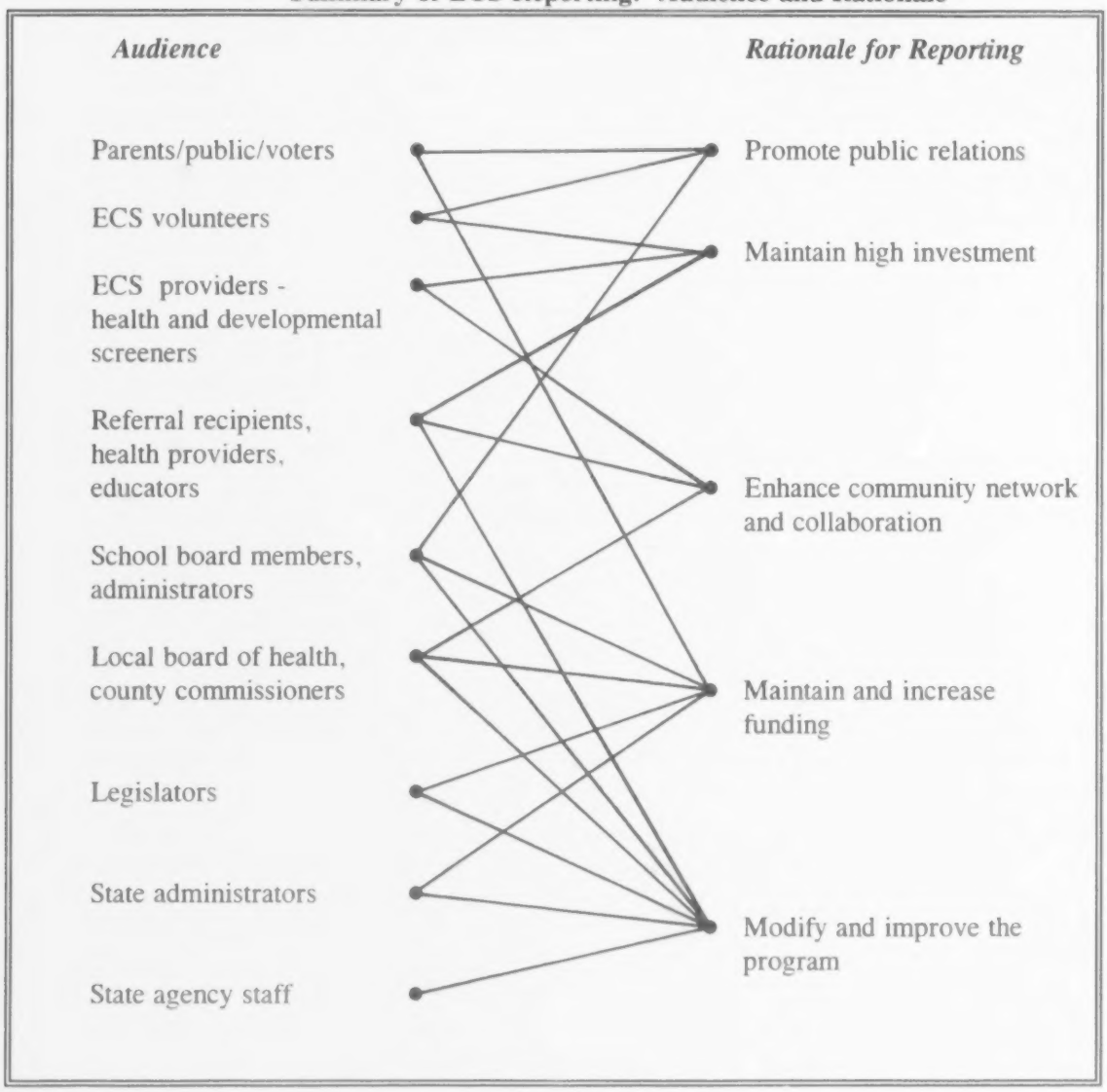
The **ECS providers** - volunteer, professionals, clinic assistants, form a team who can assist in preparing the report, should receive the report and have an opportunity for feedback. The **referral resources** are critical partners and may be further invested in ECS if provided an annual community-wide picture of the program. The local decision makers - **school board members, administrators, local county commissioners and members of boards of health** - are also key people who are regularly asked to commit personnel and/or resources to ECS.

ECS is a categorical funded program that receives biennial, sometimes annual, scrutiny from the Minnesota Legislature. In legislative hearings, nothing speaks louder than personal experience for the **legislators**, and second only is information provided by their neighbors, constituents and local administrators. Other state leaders, such as the **Governor, the Commissioner of Education, Minnesota Board of Education members, and the Commissioner of Health** can be influenced by information and comment about the programs for which they hold responsibility.

Last but not least, the **state agency staff for ECS** benefit from the questions, concerns, issues, and problems identified in local evaluation. More important are the methods of resolution and the solutions and successes reached by ECS coordinators and providers.

ECS programs are encouraged to use the **ECS PER Tool** in the first part of this chapter. The **Checklist for ECS Program** (Appendix B) can be copied annually and used as a worksheet.

Summary of ECS Reporting: Audience and Rationale



IV. INTRODUCTION TO ECS CONCEPTS

Several distinct theories offer the framework for Early Childhood Screening:

- Prevention Concepts (primary, secondary and tertiary prevention)
- Screening Principles
- Developmental Theory
- Family Issues: Balance of Demands and Resources
- Health Promotion
- Problem Solving, Decision Making Process
- Collaboration Concepts

Theories function as a guide or direction, providing a framework for organizing programs, and professional practice. In ECS, these theories are embedded in the purpose of the program as stated in the law. The theories give reason or rationale for action.

The second use of theory is as a mirror, a framework for evaluation, viewing and reviewing programs, and professional practice. A program is validated and further refined through this reflection. Major concepts of seven organizing theories are included.

A. PREVENTION CONCEPTS

Primary, Secondary & Tertiary Prevention

Prevention concepts are basic to the field of public health and have easily been adapted to education, as well.

- **Primary prevention:**
  promoting lifestyles that reduce the risk of illness or injury or other limitations, specific protection.
- **Secondary prevention:**
  early identification and prompt treatment of problems; disability limitation.
- **Tertiary prevention:**
  rehabilitation; resume remediation.

ECS is a secondary prevention (early identification) program that also serves other functions. Primary prevention is demonstrated in the parental guidance, teaching, and reinforcement of positive parenting. Introducing parents to community resources such as ECFE, Head Start, Learning Readiness, WIC programs, health resources, and others promote health and the optimum development of children.

ECS can also be a tertiary prevention activity. This is accomplished by identifying those who have lapsed from intervention for a previously known condition and supporting them to resume care or continue in a remediation program.

B. SCREENING PRINCIPLES

Definition

Screening is a process of sorting apparently well people from those who may be at risk of having potentially handicapping

conditions and are in need of more definitive study. Screening identifies early signs and symptoms and also detects asymptomatic conditions.

Screening is relatively easy and inexpensive, and allows scarce resources to be more efficiently allocated to evaluating, diagnosing, and treating/serving those at risk. Additionally, those not at risk need not become unnecessary users of the health care or special education systems. However, one key aspect of screening programs is not to replace a person or family's existing sources of care, but to ensure that all participants have access to ongoing, comprehensive health care.

Principles

The ten principles of screening programs are:

1. *The conditions sought should be important health and educational problems.*
2. *There should be an accepted treatment for those with recognized problems.*
3. *Facilities for diagnosis and treatment should be recognized and available.*
4. *There should be a recognized latent or early symptomatic stage.*
5. *There should be a suitable tool or examination.*
6. *The tool should be acceptable to the population.*
7. *The natural history of the condition, including the development from the latent to declared problem, should be understood.*
8. *There should be an agreed policy of whom to treat as clients.*
9. *The cost of case finding (including diagnosis and treatment of clients identified) should be economically balanced in relation to possible expenditure on medical care and educational services as a whole.*
10. *Case finding should be a continuing process and not a "once and for all" process.*

(Adapted from Wilson & Junger, Principles & Practice of Screening for Disease. Commissioned by World Health Organization, 1968.)

Evaluation Criteria

Evaluate screening programs according to these criteria:

1. **Yield**: number of previously unrecognized overt and latent conditions brought to treatment, and resumption of services to those with known problems who have lapsed from care.

   Yield is affected by the prevalence of a given condition in the population. Also, the yield of a program will decrease if systems are in place to identify problems earlier than at the scheduled screening program.

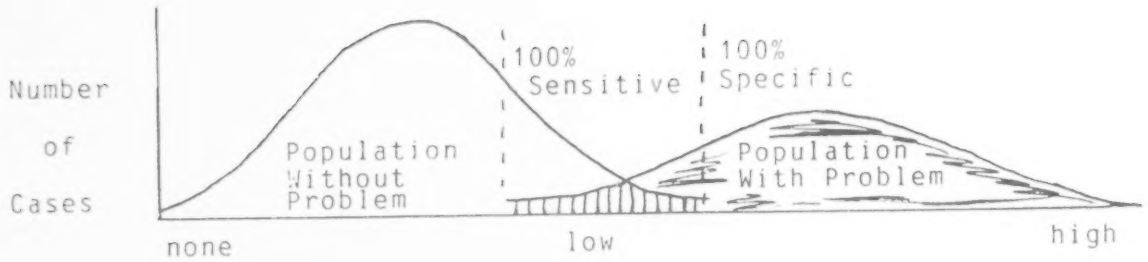
   - To increase yield: check the reliability and sensitivity of the screening tools and procedures; enhance follow-up activities to encourage those who are reluctant to seek diagnosis and treatment.

2. **Reliability or efficiency**: consistency of a tool to measure what is intended to be measured; precision, and repeatability.

   - To increase reliability: use standardized procedures, train and retrain the screeners, supervise screeners and randomly recheck findings.

3. **Validity**: the ability to identify conditions or questions; confirmation of screening findings through diagnosis. Validity is measured in accuracy of the tool, measurability of the conditions in question, individuality of the subjects, sensitivity, and specificity.

Ideally, all screening programs are **sensitive** enough to identify all cases of a given problem (100%) sensitive), yet **specific** enough to identify only those cases (100% specific). The illustration below indicates the dilemma of possible over-referral (when tools are highly sensitive) and under-referral (when screening is highly specific).



Presence of Signs of a Problem to be Identified at Screening

- To improve validity: Use accurate, precise screening methods and instruments, and well-trained staff. Using a number of related components in a screening program integrates and validates the findings of individual components: combination of tools (audiometric screening and health history of hearing problems), series of tools to increase specificity (three procedures for vision - muscle balance screening), and tools in parallel to increase sensitivity (parent report plus direct observation using a standardized tool for developmental screening).

Types of Screening Tools

• **Researched, standardized screening tools** are appropriate for conditions when the signs and symptoms are clearly identifiable and measurable. Normative distribution of the results for the tools or instruments have been calculated on large populations (or local norms may be established) and have strict protocol for administration. Standardized tools usually have scores or other specific criteria of measurement. Standardized tools may be delivered by nonprofessional staff specifically trained and appropriately supervised. Standardized tools used at ECS include the HOTV tool for visual acuity, audiometric screening for hearing acuity, growth screening (height and weight measurement, graphed), and the direct-observation-developmental screening tools.

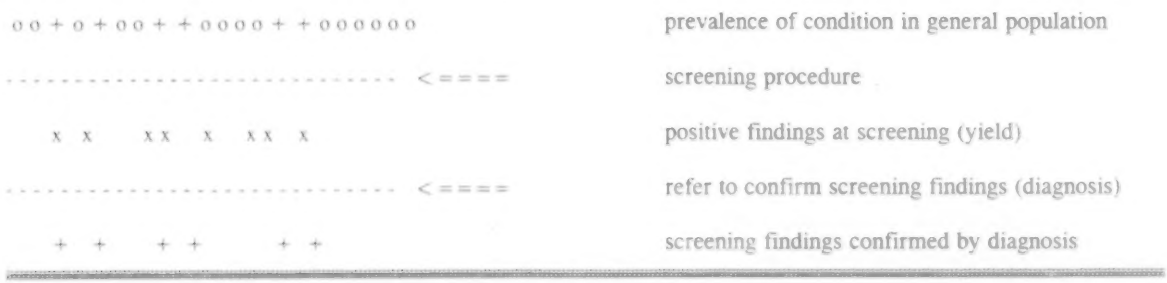
• **Clinical screening tools**, on the other hand, offer a framework that guides a professional through observation, analysis and synthesis of information. Clinical tools call for clinical judgement within broad criteria for referral and must be administered by professional staff. Clinical tools used in ECS are the health history and the family factors interview guides. The summary interview is also a clinical process that requires analysis and synthesis.

Screening is not a performance test. Tools used in ECS are to measure current status of growth and development — a marker of individuality, not of achievement. Every effort should be made to avoid the perception of a testing program. Tools or instruments are used, **not tests**. Results should be labeled as **"OK", "rescreen"** or **"refer"** — NOT "pass" or "fail."

Relationship of Screening to Diagnosis and Treatment

Screening is not a direct health care service, but an avenue to appropriate services. Screening is only relevant and useful if those identified as having potential problems obtain confirmation by examination or diagnosis, and receive the subsequent necessary treatment or services. (Implicit in this statement is an understanding that the condition can be diagnosed and that resources are available for remediation of the problem.) The critical component, then, is follow-up. Without follow-up to ensure those identified seek treatment (the yield factor), the benefits of screening activities are questionable. Below illustrates the screening stages:

Screening Stages


o o + o + o o + + o o o o + + o o o o o o
prevalence of condition in general population
- <= = = =
screening procedure
x x x x x x x x x x x
positive findings at screening (yield)
- <= = = =
refer to confirm screening findings (diagnosis)
+ + + + + +
screening findings confirmed by diagnosis

Frankenburg, W. And B. Camp, Eds. Pediatric Screening Tests. Springfield, Illinois: Charles C. Thomas, 1975.
Mausner, J., and A. Bauhn, Epidemiology, An Introductory Text. Philadelphia: W.B. Saunders, 1974.
Wold, S. School Nursing, A Framework for Practice. North Branch, MN: Sunrise River Press, 1981.

C. DEVELOPMENTAL THEORY

Principles of Child Development

1. Development presupposes potentiality. Anything that develops must have the potential for becoming what it eventually becomes.
2. Development is orderly and predictable. It follows a general sequence in all human beings resulting in greater self-control and greater awareness of others.
3. Development is individual. Each person's development is unique in pace, style and specific content.
4. Development is continuous. It goes on for one's lifetime.
5. Development is regulated by maturation. Changes occurring in the body make new behaviors possible.
6. Development is cumulative. It builds on previous experiences.
7. Development is progressive. A later stage will always be different from a previous state and it is usually more complex and integrated.
8. Development is usually irreversible but regression to an earlier level of development is both normal and useful at times for the young child.
9. Development has a rhythm, a temporal order or pattern.
10. Development is shaped by experience. Experiences in the physical world and experiences with others influence development.*

*Moncada, C. Ed. Some Essential Learner Outcomes and Interaction Suggestions In Early Childhood Education. St. Paul, Minnesota: Minnesota Department of Education, 1978, p. 3.

These principles give credence to the need for periodic measurements of growth and development, and validate the use of standardized tools specific to age.

These concepts also support the parental guidance activities of ECS. Parents are not only reinforced for skills that enhance growth and development, but they also learn to anticipate stages and characteristics of their growing child. This is an essential service to parents, particularly as children approach school entrance and need school-readiness skills.

The process and outcome of parental guidance at ECS is sometimes difficult to document but has often been declared by ECS providers and parents as the most important aspect of the program.

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D. FAMILY FACTORS: BALANCING DEMANDS AND RESOURCES

There is a wealth of research describing families and some knowledge of how family functioning affects the development of young children. There are several disciplines within medicine, health, social services, and now education that claim expertise in assessment and intervention of family systems, functioning and, roles.

There are also critical question raised when education professionals focus on the family: who provides the definition of a well, healthy functional family; intrusiveness/privacy; right of the school to know family information; professional bias in judging family systems; and recognizing and appreciating cultural/ethnic diversity.

In the optional Family Factors component of Early Childhood Screening, parents participate in a process-oriented interview using the Family Information Sheet and accompanying Family Factors Guidelines. This is not a scored tool/instrument; this is a time for dialogue, for parents to understand more about how what is happening in the family can impact their children's learning, growth and development, now and in the future.

The elements of the interview are:

- Emphasize family strengths - resourcefulness and capacity.

- Identify needs/concerns/stresses in the family in two ways:
  1. The parent(s) recognizes and initiates discussion of the stresses that may interfere with his/her/their child's growth and development; or
  2. the ECS screener/summary interviewer notes, through the interview process, stresses in family function, roles or resources and discusses these with the parent.

- The parent(s) and screener together assess the balance of the family's strengths/resources and the needs/stresses, and the steps needed to access resources.

The interview focuses on:

- Home, child care, and early childhood education

- Health care access and health care information

- Family information/development

The interview must be honest, respectful, and meaningful for the parent.

The Family Factors screening component is based on these concepts:

1. Balancing family resources and stresses (Dunst; McCubbin)

2. Review family factors while focusing on child (Summers et al.; FISC)

3. Critical family factors interfering with development (Ypsilanti study - see next page)

See the MDE, Family Factors Guidelines, 1993, available from MES (Minnesota Educational Services), Capitol View Center, 70 West Co Rd. B2, Little Canada, MN 55117-1402; 800-652-9024; 612-483-4442; Catalog # E1103; $2.50 in Minnesota.

POTENTIAL RISK FACTORS FOR CHILDREN AND FAMILIES

The Minnesota Legislature reviewed the risk factors outlined by longitudinal studies in Ypsilanti, Michigan, when they added the new component to ECS and when they designed the Learning Readiness initiative in 1991. (The 1993 Legislature ruled that the Family Factors component could be an optional, not a required screening component of ECS). The Ypsilanti factors and others identified through the literature and by ECS screeners have been incorporated into the ECS Family Factors parent questionnaire (family information sheet) and/or are included in the interviewer guide as follow-up questions.

ECS screeners will find this list of risk factors useful:

1. as rationale to administrators and to parents for the Family Factors component,
2. as a guide when looking for patterns or clusters of stresses in families in the community, and
3. during the synthesis of the Family Factors component or the Parent Summary Interview, setting priorities for what needs to be addressed further and included in the Learning Readiness plan.

CHILD CARE AND EARLY EDUCATION
Father/Mother absent from family
Change residence two or more times in the past year
Absence of friends/relatives in local area
History of severe delays of developmental milestones
Child qualifying for special education services
Referral for special education without the child qualifying

HEALTH CARE
Family income (AFDC/MA)
Social agencies indicate family in need of assistance

FAMILY RESOURCES AND NEEDS
Father/Mother absent from home
Age of Mother at birth of first child
Primary caregiver - no GED or high school diploma
Siblings who are one or more grades behind age-appropriate grades in school or who are in special education
History of high risk pregnancy and/or birth
Frequent or chronic illness of parent
Frequent or chronic illness of child
History of chemical use in family
Family history of physical, sexual or psychological abuse/neglect
Family stress in past year (death, divorce, incarceration, unemployment)
Family Income - AFDC or eligible for free/reduced lunch

PARENT PERCEPTIONS
Perception of child as being a problem child
Absence of friends/relatives in local area

Adapted from High Risk Index-Preschool, Ypsilanti Public Schools, Ypsilanti, Michigan, March, 1987.

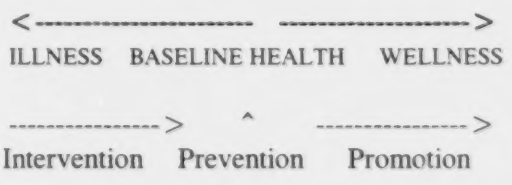
E. HEALTH PROMOTION

Definitions:

Health - the absence of physical symptoms, a feeling of well-being, able to carry out activities of daily living.

Wellness - a lifestyle approach to realizing one's best potential, emotional serenity and zest for living, and mental peace through clarity of purpose.

HEALTH CONTINUUM



Health promotion is a continuous process of encouraging and sustaining life-style practices that lead to optimum levels of

functioning and experience for all individuals.

- Intervention: assisting clients in moving from a state of illness (or a problem condition) toward baseline health. The health promoter offers guidance and counseling by coupling concerns with individual, family and community resources. (Intervention, depending on the case, is a tertiary prevention activity.)

- Prevention/Maintenance: maintaining baseline health through measures that protect one from illness or injury, and reinforce current knowledge and skills. (Primary and secondary prevention activities.)

- Promotion /Enhancement: assisting clients to experience the dynamic state of wellness through improved lifestyle practices.

In all these phases of health promotion, the client is the key actor, and the clinician is a facilitator. Health promotion involves learning decision making skills that emphasize personal responsibility. The client becomes better equipped to make personal decisions that affect his/her own health and well being and that of his/her family.

Although an essential and regular aspect of ongoing health care, health promotion has recently received more attention. The rising cost of health care, a movement towards self-reliance and consumer advocacy in all aspects of life, and new health information contributes to this trend.

Lifestyle, the daily decisions individuals make that affect their health and over which they have some control, offers a much greater potential for improved health than the other variables of environment, human biology and access to and services offered on the health care system.

Children are greatly influenced by their parents as they develop and establish patterns of behavior, processes of adaptation and decision making skills. Both children and parents are participants in the health promotion activities associated with screening programs. At each phases of Early Childhood Screening, parents have the opportunity to identify concerns, be involved in a decision making process, and parents and children gain a better understanding of health and development. All attempts at promoting healthy lifestyles for children and families have potential life-long benefits.

Bruhn J.G. and F.P. Cordova. A developmental approach to learning wellness behavior: Part I: Infancy to early adolescence; Part II. Adolescence to maturity. Health Values: Achieving High Level Wellness, November/December, 1977, pp. 246-254 and January/February, 1978, pp. 16-21.

E. PROBLEM SOLVING

The problem solving process is a systematic way of applying knowledge and skills to achieve clearly defined goals. It organizes work and practice into sequential steps. The process is a knowledgeable, purposeful series of thoughts and actions.

The process has different labels depending on the profession. Known as the nursing process to health care providers and the process of diagnosis and treatment in the medical field, educators follow the same steps in educational planning for individual students, curriculum development, and program evaluation. The logical steps discourage practice that is guided by intuition and encourage practice by systematic process.

Steps and increments of steps may vary, but all include basically assessment, intervention, and evaluation.

AWARENESS - Information gathering

SCREENING/ASSESSMENT -Measurement of signs, symptoms

DECISIONS/DIAGNOSIS

PLAN/ACTION INTENTION

IMPLEMENTATION/INTERVENTION/ ACTION

EVALUATION/ REASSESSMENT

The problem solving/decision making process is used repeatedly in ECS, from planning, evaluating and reporting the program as a whole, to problem solving with an individual parent and child on a specific concern or group of concerns.

All of the screening activities are part of the first step in the problem solving process, data collection. After screening, more information is sought to determine the educational, nursing or medical diagnosis. Caution should be taken not to use screening data as the sole basis of placement decisions for students in special education or for health care plans.

The manager of ECS and the providers consistently apply the process. There is also an opportunity to teach parents the same logical, systematic way to approach problems. Using the experience of identifying a concern at screening to further data collection, diagnosis, plan implementation and evaluation, the ECS provider can reflect with the parent at each step in the process. ECS can not only be the first step in problem identification and resolution, it can also be a vehicle to teach and reinforce decision making skills.

Iverson, C., Ed.
Health and Developmental History Assessment Skills Manual, 2nd ed. Scarborough, ME: NASN, 1983

E. COLLABORATION CONCEPTS

Collaboration is a means to reach goals that cannot be achieved as efficiently by individuals or agencies acting singly.

The purpose of ECS includes coordinating with other early childhood programs, reducing duplication of screening services, and improving access to programs. ECS links children to Learning Readiness and connects children and families with Early Childhood Family Education. To meet these goals ECS programs develop referrals for evaluation of and intervention for health and developmental concerns when indicated.

Interagency Collaboration

ECS and other early childhood programs and health agencies can provide coordinated approaches to solving the problems that children and families face. When different agencies can recognize that they share many common goals for children, cooperation can improve outcomes. Collaboration among agencies involves an acknowledgment that meeting the child and/or families needs is best done together.

There are four levels of interagency involvement. Collaboration begins as a step by step process but evolves into a circular process. Collaboration always depends on communication, continued coordination, and on-going cooperation.

I. **Communication**
Activities:
1. Meeting with all interested agencies to discuss the needs of children and families
2. Define available resources
3. Develop goals to meet identified problems or aims
4. Identify obstacles

II. **Coordination**
Activities:
1. Develop action plans, and timelines to meet goals
2. Each member seeks ways to help meet the shared goals
3. Develop linkages with other programs

III. **Cooperation**
Activities:
1. Define contributions and responsibilities of individual agencies or programs
2. Organize the participants so that decisions can be made

IV. **Collaboration**
Activities:
1. Design approaches to meet the goals
2. Identify outcome measures and evaluate improvement

Collaboration among ECS and other programs is working if interdisciplinary outcome measures show improvement. For example, increased numbers of families participating in ECFE, improved immunization rates, increased numbers of completed hearing or vision referrals, improved parent use of behavior management strategies, increased numbers of health care providers accept children for care who do not have health coverage, a new program to meet the needs of the community's preschoolers (as identified at ECS) has been planned.

P. Seppanen and J Heifetz.
Community Education as a Home for Family Support and Education Programs.
Cambridge, MA: Harvard Family Research Project, 1988.

Thinking Collaboratively: Ten Questions and answers to Help Policy Makers Improve Children's Services.
Washington, DC: Education and Human Services Consortium, 1991.

APPENDICES

NOTE: These documents may change annually due to legislative or policy changes in ECS. Contact MDE for the current forms.

A. **Minnesota Statutes and Rules**
Minnesota Statute 123.701-.7045, revised 1993 . . . . . A-1
Education Statutes Related to Early Childhood Screening A-3
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EARLY CHILDHOOD SCREENING - Statute

6/4/93

MINNESOTA STATUTE 123.701 PURPOSE. **1977**

The Legislature finds that early detection of children's health and developmental problems can reduce their later need for costly care, minimize their physical and educational handicaps, and aid in their rehabilitation. The purpose of section 123.701 to 123.705 is to assist parent and communities in improving the health of Minnesota children and in planning educational and health programs.

MINNESOTA STATUTE 123.702 SCHOOL BOARD RESPONSIBILITIES. **1993**

Subdivision 1. Every school board shall provide for a mandatory program of early childhood developmental screening for children once before school entrance, targeting children who are between 3-1/2 and 4 years old. This screening program shall be established either by one board, by two or more boards acting in cooperation, by educational cooperative service units, by early childhood family education programs, or by other existing programs. This screening examination is a mandatory requirement for a student to continue attending kindergarten or first grade in a public school. A child need not submit to developmental screening provided by a school board if the child's health records indicate to the school board that the child has received comparable developmental screening from a public or private health care organization or individual health care provider. The school districts are encouraged to reduce the costs of preschool developmental screening programs by utilizing volunteers in implementing the program.

Subd. 1a. A child must not be enrolled in kindergarten in a public school unless the parent or guardian of the child submits to the school principal or other person having general control and supervision of the school a record indicating the months and year the child received developmental screening and the results of the screening not later than 30 days after the first day of attendance. If a child is transferred from one kindergarten to another, the parent or guardian of the child must be allowed 30 days to submit the child's record, during which time the child may attend school.

Subd. 1b. (a) A screening program shall include at least the following components: developmental assessments, hearing and vision screening or referral, immunization review and referral, the child's height and weight, identification of risk factors that may influence learning, an interview with the parent about the child, and referral for assessment, diagnosis, and treatment when potential needs are identified. The school district and the person performing or supervising the screening shall provide a parent or guardian with clear written notice that the parent or guardian may decline to answer questions or provide information about family circumstances that might affect development and identification of risk factors that may influence learning. The notice shall clearly state that declining to answer questions or provide information does not prevent the child from being enrolled in kindergarten or first grade if all other screening components are met. If a parent or guardian is not able to read and comprehend the written notice, the school district and the person performing or supervising the screening must convey the information in another manner. The notice shall also inform the parent or guardian that a child need not submit to the school district screening program if the child's health records indicate to the school that the child has received comparable developmental screening performed within the preceding 365 days by a public or private health care organization or individual health care provider. The notice shall be given to a parent or guardian at the time the district initially provides information to the parent or guardian about screening and shall be given again at the screening location.

Subd. 1b. (b) All screening components shall be consistent with the standards of the state commissioner of health for early developmental screening programs. No developmental screening program shall provide laboratory tests, or a physical examination to any child. The school district shall request from the public or private health care organization or the individual health care provider the results of any laboratory test, or physical examination within the 12 months preceding a child's scheduled screening.

Subd. 1b. (c) If a child is without health coverage, the school district shall refer the child to an appropriate health care provider.

Subd. 1b. (d) A school board may offer additional components such as nutritional, physical and dental assessments, review of family circumstances that might affect development, blood pressure, laboratory tests, and health history. State aid shall not be paid for additional components.

Subd. 1b. (e) If a statement signed by the child's parent or guardian is submitted to the administrator or other person having general control and supervision of the school that the child has not been screened because of conscientiously held beliefs of the parent or guardian, the screening is not required.

Subd. 2. If any child's screening indicates a condition which requires diagnosis or treatment, the child's parents shall be notified of the condition and the school board shall ensure that an appropriate follow-up and referral process is available.

Subd. 3. The school board shall inform each resident family with a child eligible to participate in the developmental screening program about the availability of the program and the state's requirement that a child receive developmental screening not later than 30 days after the first day of attending kindergarten in a public school.

Subd. 4. A school board may contract with or purchase service from an approved early developmental screening program in the area. Developmental screening must be conducted either by an individual who is licensed as, or has training that is similar to a special education teacher, school psychologist, kindergarten teacher, prekindergarten teacher, school nurse, public health nurse, registered nurse, or physician. The individual may be a volunteer.

Subd. 4a. The school district shall provide the parent or guardian of the child screened with a record indicating the month and year the child received developmental screening and the results of the screening. The district shall keep a duplicate copy of the record of each child screened.

Subd. 5. Every school board shall integrate and utilize volunteer screening programs in implementing sections 123.702 to 123.7045 wherever possible.

Subd. 6. A school board may consult with local societies of health care providers.

Subd. 7. In selecting personnel to implement the screening program, the school district shall give priority first to qualified volunteers.

MINNESOTA STATUTE 123.704 DATA USE. 1982

Data on individuals collected in screening programs established pursuant to section 123.702 is private, as defined by section 13.02 subdivision 12. Individual and summary data shall be reported to the school district by the health provider who performs the screening services, for the purposes of developing appropriate educational programs to meet the individual needs of children and designing appropriate health education programs for the district; provided, no data on an individual shall be disclosed to the district without the consent of that individual's parent or guardian.

MINNESOTA STATUTE 123.7045 DEVELOPMENTAL SCREENING AID. 1993

Each school year, the state shall pay a school district $25 for each child screened according to the requirements of section 123.702. If this amount of aid is insufficient, the district may permanently transfer from the general fund an amount that, when added to the aid, is sufficient. [NOTE: This sentence is not new language, but was moved from a note in the statute to a numbered section.]

Changes by the 1993 Legislature, Omnibus Education Act, Article 4, Sections 12 -18 and Section 44, Sub.7.

MDE/ECS/REL 4/95

EDUCATION STATUTES RELATED TO EARLY CHILDHOOD SCREENING

6/4/93

* Direct statutory references to Early Childhood Screening (ECS) in other education programs.
++ Additional key areas linking Early Childhood Screening to other programs.

MINNESOTA STATUTE 121.831 LEARNING READINESS PROGRAMS **1993**
(Portions of the Learning Readiness program, not the complete reference.)

Subdivision 1. [ESTABLISHMENT; PURPOSE.] A district or a group of districts may establish a learning readiness program for eligible children. The purpose of a learning readiness program is to provide all eligible children adequate opportunities to participate in child development programs that enable the children to enter school with the necessary skills and behavior and family stability and support to progress and flourish.

Subd. 2. [CHILD ELIGIBILITY.] (a) A child is eligible to participate in a learning readiness program offered by the resident district or another district if the child is:

(1) at least three and one-half years old but has not entered kindergarten; and

* (2) receives developmental screening to under section 123.702 within 90 days of enrolling in the program or the child's fourth birthday.

(b) A child younger than three and one-half years old may participate in a learning readiness program if the district or group of districts that establishes the program determines that the program can more effectively accomplish its purpose by including children younger that three and on-half years old.

Subd. 3. [PROGRAM ELIGIBILITY.] A learning readiness program shall include the following:

++ (1) a comprehensive plan to anticipate and meet the needs of participating families by coordinating existing social services programs and by fostering collaboration among agencies or other community-based organizations and programs that provide a full range of flexible, family-focused services to families with young children;

(2) a development and learning component to help children develop appropriate social, cognitive, and physical skills, and emotional wellbeing;

++ (3) health referral services to address children's medical, dental, mental health, and nutritional needs;

(4) a nutrition component to meet children's daily nutritional needs; and

(5) parent's involvement in meeting the educational, health social service, and other needs.

++ (6) community outreach to ensure participation by families who represent the racial, cultural, and economic diversity of the community; and

(7) community-based staff and program resources, including interpreters, that reflect the racial and ethnic characteristics of the children participating in the program.

Subd. 4. [PROGRAM CHARACTERISTICS.] Learning readiness programs are encouraged to:

++ (1) prepare an individualized service plan to meet each child's developmental and learning needs;

++ (2) provide parent education to increase parents' knowledge, understanding, skills and experience in child development and learning;

(3) foster substantial parent involvement that may include having parents develop curriculum, or serve as a paid or volunteer educator, resource person, or other staff;

++ (4) identify the needs of families in the context of the child's learning readiness;

++ (5) expand collaboration with public organizations, businesses, nonprofit organizations, or other private organizations to develop a coordinated system of flexible, family-focused services available to anticipate and meet the full range of needs of all eligible children and their families;

++ (6) coordinate treatment and follow-up services for children's identified physical and mental health problems;

(7) offer transportation for eligible children and their families for whom other forms of transportation are unavailable or would constitute an extensive financial burden;

(8) make substantial outreach efforts to assure significant participation by families with the greatest needs, including those families whose income levels does not exceed the most recent update of the poverty guidelines required by section 652 and 673 (2) of the Omnibus Reconciliation Act of 1981 (Public Law Number 97-35);

(9) use community-based trained home visitors serving as paraprofessionals to provide social support, referrals, parent education, and other services;

(10) create community-based family resource centers and interdisciplinary teams; and

(11) enhance the quality of family or center-based child care programs by providing supplementary service and resources, staff training, and assistance with children with special needs.

. . . .

++ Subd. 6. [COORDINATION WITH OTHER PROVIDERS.] (a) The district shall coordinate the learning readiness program with existing community-based social services providers and foster collaboration among agencies and other community-based organizations and programs that provide flexible, family-focused services to families with children. The district shall actively encourage greater sharing of responsibility and accountability among service providers and facilitate children's transition between programs.

. . . .

* Subd. 8. [PRIORITY CHILDREN] The district shall give greatest priority to providing services to eligible children identified, through means such as the early childhood screening process, as being developmentally disadvantaged or experiencing risk factors that could impede their learning readiness.

MINNESOTA STATUTE 121.882 HOME VISITING PROGRAM **1993**

Subd. 2b. [HOME VISITING PROGRAM]

(Include as a part of early childhood family education programs a parent education component to prevent child abuse and neglect.)

(b) The parent education component must:

++ (1) develop a risk assessment tool to determine the level of risk.

MINNESOTA STATUTE 124.2721 EDUCATION DISTRICT REVENUE **1991**

Subd. 5a. [USES OF REVENUE.] For fiscal year 1994 and thereafter, education district revenue shall be used only for one or more of the following purposes: ...

* (4) provide additional revenue for early childhood health and developmental screening or other health services for children from birth through 12th grade;

EARLY CHILDHOOD SCREENING - Rules - 1993 Revisions

7/28/93

NOTE: The Minnesota Legislature enacts laws that are coded and recorded as Minnesota Statutes - this process usually occurs within the timeframe of the legislative session - from three to six months. The Minnesota State Board of Education is authorized to promulgated Rules to implement education laws. Rules carry the weight of law in that they must be followed in implementation of programs. The rule-making process requires extensive research, public notice through publication in the State Register, advice from legal counsel, and regional meetings for input on Rule changes - taking usually a year, sometimes longer. If there is a difference between law and rule, the law has precedence.

Minnesota Rules for Early Childhood Screening (ECS) were established in 1978 following the Legislature's 1977 inception of the program. The Rules were last revised in 1985. Some rules were outdated due to changes made by the Legislature in the statutes. In some cases language from the rule had been incorporated into law resulting in unnecessary duplication. Other ECS rules continue to be relevant and provide guidance to implementation of the program.

In 1993 the Legislature took the unusual action of reviewing not only all statutes pertaining to education, but also all rules. Some sections of the ECS rules were deleted. Those deleted were the outdated ones due to changes in statute and rules that were duplicative of statutory language. The remaining rules listed here were not edited word for word during by Legislative during its session. Therefore, some details in the remaining sections are not current; editorial explanations by MDE staff are offered in brackets when necessary. These rules are listed with the old refererence numbers. They will no doubt be recodified (renumbered and put into the "code" of rule later in 1993.

MINNESOTA RULE 3530.3000 DEFINITIONS.

Subpart 1. Scope. As used in parts 3530.3000 to 3530.4310, the terms defined in this part have the meanings given them.

Subp. 2. Assessment. "Assessment has the same meaning as "screening."

Subp. 3. Developmental screening. "Developmental screening" means identification of the motor, language, social-emotional, and cognitive status of the child.

Subp. 4. Health maintenance referral. "Health maintenance referral" means a referral made for periodic medical or dental examinations, immunizations, or health or nutritional counseling.

Subp. 5. Licensed, registered, or certified. "Licensed," "registered," or "certified" means licensed, registered, or certified in Minnesota.

Subp. 6. Parent. "Parent" means the mother, father or legally appointed guardian. If a child is a ward of the commissioner of human services or other public official, the parent is the commissioner or such official. If the parent or guardian is unknown or cannot be found after reasonable efforts have been made, the parent is an agency or other person appointed pursuant to Minnesota Statutes or court order.

Subp. 7. Early childhood health and developmental screening program. "Early childhood health and developmental screening program or "screening program" means the systematic procedures developed to conduct screening of preschool children.

Subp. 8. Referral. "Referral" means an organized system for providing information to the parent at the summary interview about the names of agencies or providers to possibly be used for evaluation or diagnosis.

Subp. 9. Screening. "Screening" means the use of procedures to sort out apparently well children from those in need of more definitive study of health or developmental problems.

Subp. 10. Screening personnel. "Screening personnel" means professional, paraprofessional, and volunteer staff who conduct activities as part of the screening program.

3530.3100 PARTICIPATION IN PROGRAM AND DELIVERY OF SERVICES

Subp. 1. Available screening. All children shall have available without cost the services of trained personnel to screen for possible health and developmental problems once prior to entering school.

Subp. 2, 3, 4 deleted.

Subp. 5 Exclusion from providing screening. If an individual or group is excluded from performing a screening, it may submit a complaint to the school board. The school board must take action it determines is advisable.

3530.3200 SCHOOL DISTRICT REPORT

Subp. 1, 2, 3, 4, 5 deleted.

Subp. 6. Final aid payment. The final aid payment shall be paid at the conclusion of the screening program or the fiscal year, whichever occurs first. A district's plan must have been approved and report submitted before the aid is paid. [NOTE: Plans are not requested annually, only when there are major changes in ECS such as in 1988 when the comprehensive program for three-year olds was introduced. Payment is on a metered schedule, 85% being paid throughout the school year; a 15% final payment is made in the fall following the program year.]

3530.3300 SCREENING PROGRAM STAFF.

Subpart 1. Early childhood screening coordinator. Each district shall designate an early childhood screening coordinator to be responsible for administering all components of the screening program. The coordinator may be a volunteer.

Subp. 2. Screening personnel. In selecting personnel for screening programs, school districts shall give first priority to volunteers who have the qualifications required by subparts 4 to 9. Second priority shall be given to others who possess at least minimum qualifications and who can provide services determined to be most cost effective. Personnel may perform one or more of the functions described in this part if they meet each of the qualifications.

Subp. 3. Services delegated by professionals. If a qualified professional delegates services, the professional must assure that all delegated services comply with parts 3530.3000 to 3530.4310 and that adequate supervision is provided. The professional is responsible for services delegated and provided by other persons.

Subp. 4. Professional health screener qualifications. A person who performs professional health screening must be a licensed medical physician, dentist, registered nurse, chiropractor, optometrist, podiatrist, or psychologist. A professional health screener who is not a licensed physician, or a registered nurse must have successfully completed Department of Health training seminars or equivalent training programs to prepare individuals to perform child screening. The seminars or programs must be designated by the Department of Health in consultation with the State Department of Education.
[NOTE: This section pertains to the growth screening component (height and weight) and the optional components of the health history and nutrition assessment and physical examination.]

Subp. 5. Developmental screener qualifications. A person who performs developmental screening without supervision must be licensed as a special education teacher, school psychologist, kindergarten teacher, prekindergarten teacher, registered nurse, or licensed physician and must have completed training seminars provided by the State Department of Education or equivalent training as determined by the State Department of Education in consultation with the Department of Health. Other persons who perform developmental screening must meet supervision requirements in subpart 8.
[NOTE: Training programs are not offered for ECS developmental screening. After fifteen years of the ECS program, the establishment of early childhood special education programs, early childhood family education programs and public/school health programs for young children, state agencies depend on the expertise of professional educators and health professionals to select instruments that meet the program standards and to use the protocols in the instruments for annual training and accurate implementation of the development component. MDH provides a training program for the Denver II which meets the standards for an ECS tool and is also widely used by private and public health providers.]

Subp 6. Vision and hearing screener qualifications. A person who performs vision or hearing screening must have been trained by the Department of Health to perform vision or hearing screening; or a program providing equivalent preparation as determined by the Department of Health in consultation with the State Department of Education.

Subp. 7. Laboratory assistant qualifications. A person who performs laboratory tests must have been trained by the Department of Health to perform the specific tests used in the screening program; or a program providing equivalent preparation as determined by the Department of Health in consultation with the State Department of Education.

Subp. 8. Clinic assistant qualifications. A clinic assistant is a lay person or a paraprofessional who may perform any component of the screening program. The clinic assistant must be under the supervision of a professional qualified for the screening component for which the clinic assistant is used. The professional must be present at the screening site. A clinic assistant must have been trained by State Department of Education or Department of Health professional staff to administer the health or developmental screening measures to be performed by the clinic assistant; or a program providing equivalent preparation as determined by the State Department of Education or the Department of Health.
[NOTE: An example of a training program is MDH's program for vision and hearing screening taught to volunteers, paraprofessionals and professionals. MDH also has a train-the-trainer series whereby professionals are prepared to then train volunteers or paraprofessionals in their local areas.]

Subp. 9. Dental screener qualifications. A person who performs dental assessments must be a:

A. licensed dental hygienist or a registered or certified dental assistant; or

B. registered nurse who has been trained by the Department of Health or approved by the Department of Health in consultation with the State Department of Education, as having been trained to perform dental screening; or

C. licensed dentist, licensed physician, school nurse practitioner, or pediatric nurse practitioner using screening procedures according to parts 3530.3400 to 3530.4310.

Subp. 10. Equivalent training programs. The Department of Health, in consultation with the State Department of Education, shall approve a program as providing equivalent training for the purpose of subparts 4, and 6 to 8 if the program meets all of the following:

A. it provides information and training required to perform the specific screening and referral activities specified in subparts 4, and 6 to 9;

B. it must offer the same or greater number of course contact hours as the Department of Health training seminars;

C. the instructor qualifications must be at least equivalent to the instructor qualifications of Department of Health training seminar instructors; and

D. the course materials must be consistent with materials used in Department of Health training seminars.

Subp. 11. Volunteer. A volunteer may be a lay person, paraprofessional, or professional who performs screening without fee or payment. A volunteer may perform any of the screening components if the volunteer meets the qualifications established in this part.

[NOTE: For Family Factors screening personnel, see the MDE guideline booklet.]

3530.3400 SCREENING PROCEDURES.

[NOTE : The old rule listed and defined required components in this section and optional components in the next, and with nearly annual changes in as to required and optional components in statute, the rule was not up to date. The list of required components is now in statute and has been deleted from the rule except for developmental screening below. Definitions and standards for the current components - required and optional - are to be consistent with the standards set by the Minnesota Department of Health (see MS 123.702, Subd. 1b (b)).]

Subp. 1, 2 deleted.

Subp. 3. Developmental tests. A developmental screener must measure the child's cognition, fine and gross motor skills, speech and language, and social-emotional development. The procedures must include at least:

A. a parent report of the child's functioning history in skills development, emotional status, and behavior status; and

B. direct observation of the child's functioning. Standardized developmental screening instruments approved by the State Department of Education must be used. They must contain norms for the age range tested and written procedures for administration, scoring, and interpretation.

Subp. 4, 5, 6, 7 deleted.

3530.3500 OPTIONAL COMPONENTS.

Sections A-E deleted.

3530.3600 DUPLICATION OF SERVICES.

Deleted.

[NOTE: Statute now includes requirements to reduce duplication of services. Children are not to receive the school's ECS program if their health records indicate they have received a comparable screening (MS 123.702, Subd. 1) within the 365 days preceding the school's program (MS 123.702, Subd. 1b. (a)).]

3530.3700 PRIVATE DATA.

Data on individual children is private as defined by state statutes and shall not be disclosed to a third party, including the district, without the informed consent of the parent. All information must be made available to the parent.

3530.3800 INCLUSION IN SCHOOL RECORDS.

Data on individual children obtained in the screening program shall be incorporated into school district records, except as indicated in part 3530.3700. Screening data that are not substantiated may not be incorporated in the child's school record as confirmed health or developmental problems.

3530.3900 REFERRALS

Deleted.

[NOTE: See the rules, Subp. 8 for the definition of referral. Referral criteria are set by MDH when it defines the standards for the components of programs. Statute requires that an appropriate referral process is available (MS 123.702,2; 702, 1b (a); 702 1b (c).]

3530.4000 FOLLOW-UP ON REFERRALS.

Deleted.

[NOTE: Statute requires that an appropriate follow-up process is available (MS 123.702, 2). The Learning Readiness program is a potential avenue for followup as listed in the program characteristics (MS 121.831, Subd. 4 - 1,4,6).
Follow-up consists of contacting the parent at least twice to find out if the problem noted was or was not confirmed, if there is a course of treatment being followed for remedition and if the referral source was acceptable and accessible.]

3530.4100 MEDICAL ASSISTANCE INFORMATION.

Deleted.

3530.4200 SERVICES PROHIBITED.

Diagnosis, treatment or therapy shall not be provided in the screening program but may be provided as a part of a related program.

3530.4300 SPECIAL EDUCATION.

Educational placement decisions, diagnostic conclusions, and objectives for individual educational plans may not be based solely or primarily on the screening data made available to the district from the screening program.

3530.4310 FEES.

Districts may charge parents a fee for any of the optional screening components. Parents may refuse the optional components and receive the required components free of charge.

Changes made by the 1993 Minnesota Legislature. Omnibus Education Act, Article 12, Section 39 (a), Rules Repealer.

Unofficial copy
MDE/ECS/REL/djm 7/28/93

EARLY CHILDHOOD SCREENING

1993-94, July 1993
[no changes for 1994-95]

Minnesota Statute 123.701 - 123.7045, revised 1993 and
Minnesota Rules 3530.3000 - 3530.4310, revised 1993

This checklist includes requirements of ECS from state statutes and rules by program activity - planning, outreach, screening, follow-up and recording. Some directives are found more than once in statute and rule or apply to more than one program activity, so some items are repeated in the checklist.

The codes in parentheses refer to the statute by number such as Minnesota Statute 123.702, Subdivision 1 is listed as MS 123.702,1. For rules, Minnesota Rule 3530.3000, Subpart 2 is listed as MR 3530.3000,2.

CHECKLIST FOR ECS PROGRAM

COORDINATING/PLANNING

__ Define purpose of the program:

- __ Assist parents and communities in improving the health of Minnesota children (MS 123.701; MS 123.702,1b(a)).
- __ Design and plan educational programs (MS 123.701; MS 123.704).
- __ Plan health programs (MS 123.701; MS 123.704).
- __ Screen children for possible health and developmental problems (MR 3530.3100,1) through systematic procedures (MR3530.3000,7) to sort out apparently well children from those in need of more definitive study of health or developmental problems (MS 3530.3000,9).
- __ Develop education programs to meet the individual needs of the child (MS 123.704).
    - __ Link children to Learning Readiness (MS 121.831,2.2); identify priority children through ECS (MS 121.831,8).
    - __ Identify risk issues for families in the Early Childhood Family Education Home Visiting program (MS 121.882,2b).
    - __ Link children and families to Early Childhood Family Education.
    - __ Identify children with special needs and refer to Early Childhood Special Education or IEICs (Interagency Early Intervention Committee).
    - __ Coordinate with Head Start programs to improve access to and reduce duplication of screening services, and to improve access to programs.
    - __ _____
- __ _____
- __ _____

__ Communicate, cooperate, coordinate and collaborate with other programs and agencies:

- __ Shall establish the program either by one board, two or more boards acting in cooperation, by ECSUs, by ECFE (early childhood family education) programs, or by other existing programs (MS 123.702,1). Programs in the community may appeal to the local school board to participate in the screening program (MR 3530.3100,5).

- __ May contract with or purchase services from public health agencies or medical clinics providing Child and Teen Checkups funded by state public health and/or federal Medical Assistance (MS 123.702,4).

- __ May consult with local societies of health care providers (MS 123.702,6) in planning.

__ Communicate with physicians and community health agencies (public or private health care organizations or individual health care provider (MS 123.702,1) regarding:

- __ setting the criteria for "comparable" developmental screening program (see required components on page 3) that will be accepted as a record of screening - date and results by component - (MS 123.702,1; 1b (a)).
- __ process to request results of any laboratory test or physical examination for children seen within the 12 months preceding ECS (MS 123.702,1b(b)).
- __ ability/desire of the provider to accept referrals for chidden without health care coverage because schools are required to refer such children to an appropriate health care provider (MS 123.702,1b(c)).
- __ plan to receive referrals for assessment, diagnosis and treatment (MS 123.702,1b(a)).
- __ follow-up process for confirming children have received care, results of diagnosis and treatment, future needs of children (MS 123.702,2).

__ Communicate with staff in other early childhood programs -- education, human services, economic development or other community programs -- regarding:

- __ Coordinating screening activities (MS 123.702,4).
- __ Referral resources (MS 123.702,1b(a)).
- __ Planning education and health programs in the community (MS 123.701).
- __ Other links as required by other programs (ECFE Home Visiting, Learning Readiness)

__ Determine procedures and personnel:

__ Provide screening consistent with standards of the Minnesota Department of Health (MS 123.702,1b(b)). (MDH standards are consistent with Child and Teen Checkups (DHS administered federal program) and American Academy of Pediatric guidelines.)

__ Provide a screening program for children once before they enter school, targeting 3 1/2 to 4-year-olds (MS 123.702,1). Reimbursement will be paid for children screened ages 3 1/2 through school entrance. Offer the program to all young children in the community - future enrollees in public, nonpublic and home schools; screening is mandatory for public school enrollees.

__ Provide the required screening components at no cost to parents (MR 3530.3100,1).

__ Determine screening personnel/program staff: (MS 123.702,4; MR 3530.3000,10;3530.3300)

- __ Designate a coordinator (MR 3530.3300,1)
- __ Select individuals to conduct screening who are either licensed as or who has training that is similar to a special education teacher, school psychologist, kindergarten teacher, prekindergarten teacher, school nurse, public health nurse, registered nurse or physician (MS 123.702,4) or early childhood family educator.
- __ Determine the relationship between professional staff and clinic assistants:
  - __ Training must be provided (MR 3530.3300,6,7,8).
  - __ The professional must assure the standards are maintained; the professional is responsible for the services provided by other persons such as clinic assistants (MR 3530.3300,2).
  - __ On site supervision is required (MR 3530.3300,2 & 8).
- __ Train staff and/or annually review procedure guidelines for each component (MR 3530.3300).
- __ Utilize volunteers in implementing the program to reduce the costs of screening (MS 123.702,1 & 4); integrate and utilize a volunteer screening program whenever possible (MS 123.702,5); give first priority to qualified volunteers (MS 123. 702,7; MR 3530.3300,2).
- __ Second priority shall be given to those who posses minimum qualifications and who can provide services determined to be most cost effective (MR 3530.3300,2)

__ Determine the costs and revenue:

__ State reimbursement - $25 for children age 3 1/2 through school entrance (MS 123.7045).
__ May transfer dollars from the general fund if ECS state aid is not sufficient (MS 123.7045).
__ Consider using funds from other early childhood programs that complement ECS, such as Learning Readiness funds which may be used from the optional family factors component, to extend the summary interview or for followup.
__ May recover costs from third party payers. (Previous cost recovery requirements are repealed but some districts who will provide a comprehensive screening program are voluntarily continuing cost recovery efforts.)
__ May charge parents a fee for optional components (MR 3530.4310).

__ Set enrollment criteria and procedures for the school district.

__ Screening is a mandatory requirement for a child to be enrolled in (MS 123.702,1a) or continue attending (MS 123.702,1) kindergarten; the record may be submitted within 30 days after the first day of attendance (MS 123.702,1a).

__ Develop a plan for responding to a parent who declines screening. The parent or guardian must submit a signed statement that the child has not been screened because of conscientiously held beliefs (MS 123.702,1b (e)). The statement does not have to be notarized.

__ Review the requirements for school enrollment: a record submitted by the parent of the dates (month and year) and results of screening. Review the school district's summary form for inclusion of all components (MS 123.702.1a)).

__ Determine the criteria for accepting results of a comparable screening when
__ the child's health records indicate to the school district that the child has received a comparable screen within the 365 days prior to the school's program (MS 123.702,1b(a)); or
__ when provided by a private or public health care provider (MS 123.702,1)

EVALUATING

__ Ensure that an appropriate follow-up process is available (MS 123.702,2) including assessment, diagnosis and treatment (MS 123.702,1b (a)).

__ Use summary data for developing educational programs to meet the individual needs of children (MS 123.704).

__ Use summary data to design appropriate health education programs for the district (MS 123.704).

OUTREACH/NOTIFYING/PREPARING

__ Outreach: Inform each resident family with a child eligible to participate about availability of ECS and state's requirement that a child receive screening not later than 30 days after enrollment in kindergarten in a public school (MS 123.702,3).
__ Provide notice that a child need not submit to the school program if date and results of comparable screening are obtained from the public or private health provider (MS 123.702,1; 1b(a)).
__ Optional components: If providing the optional family factors components, provide clear written notice that the parent or guardian may decline to answer questions or provide information about family circumstances or other risk factors (MS 123.702,1b(a)).
__ From parent or guardian, obtain consent to
1) screen the child at the school (or contracted agency) program,
2) to request information from health care provider if child has been seen in the 12 months preceding screening (MS 123.702,1b(b)),
3) to disclose screening results to the school district (MS 123.704; MR 3530.3700) for kindergarten enrollment (MS 123.702,1a), Learning Readiness or any other program (MS 123.704).
__ Request from a child's health care provider the results of any laboratory test or physical examinations within the 12 months preceding screening (MS 123.702,1b(b)).

SCREENING COMPONENTS

REQUIRED COMPONENTS OF A DEVELOPMENTAL SCREENING PROGRAM (MS 123.702, 1b(a)).
These components must be offered to and provided for each child. State aid reimburses districts for the required components; if the aid is insufficient, resources may be transferred from the general fund to the ECS fund (MS 123.7045).

__ Review consent for screening, release of information [and the option to decline to answer the questions regarding family circumstances or other risk factors if provided as an optional component (MS 123.702 1b(a)].
Again notify parents that the child need not submit to the school district screening program if the child's health records indicate to the school that the child received a comparable screening within 365 days prior to the school program (MS 123.702,1b(a)).

__ Developmental screening:
Identification of the fine and gross motor skills, speech and language, social-emotional, cognitive status of the child (MR 3530.3000,3; MDE and MDH standards). The procedures must include (MR 3530.3400,3):
__ A. parent report of child's functioning history in skills development, emotional status and behavior status.
__ B. tool/test: direct observation of the child's functioning using standardized developmental screening instruments with norms for the age range tested, written procedures for administration, scoring and interpretation.

__ Hearing screening or referral (MDH standards)
(history of hearing/ear problems; puretone audiometer; tympanometry optional)

__ Vision screening or referral (MDH standards)
(history of vision/eye problems; external inspection, muscle balance, visual acuity [HOTV]).

__ Growth screening -- height and weight, graphed (MDH standards).

__ Immunization review and referral (MS 123.70; MDH standards).

__ Identification of risk factors that may influence learning (local school district determination).

__ Summary Interview with the parent about the child: (See also Referral)
__ Interview with parent about the child (MS 123.702,1b(a)) to share all information with the parent (MR 3530.3700).
__ Review information obtained from the health care provider concerning physical assessments and laboratory tests received prior to screening (MS 123.702,1b(b)).
__ Provide a record to the parent of the month/year and results of screening (MS 123.702,4a).
__ Refer for assessment, diagnosis, and treatment when potential needs identified (MS 123.702,1b(a); MS 123.702,2).
Provide information about the names and agencies or providers to possibly be used for evaluation or diagnosis (MR 3530.3000,8).

ADDITIONAL/OPTIONAL COMPONENTS
The school board may offer additional components (MS 123.702,1b(d)). State aid shall not be paid for these components. School districts may charge parents a fee for optional components (MR 3530.4310), access resources from other early childhood programs or the general fund or seek in-kind or direct funds from community public/private service agencies or volunteer groups.

__ Physical assessment and blood pressure, dental assessments (MDH standards)

__ Laboratory tests (MDH standards)

__ Health history and nutrition assessment (MDH standards)
(The MDH Health History form contains the following: health care provider and utilization, family members and family health history, birth and health history, current health status, health practices, behavior review, lead exposure risk, nutrition review, immunization review)

__ Review of any special family circumstances that might affect development. (MDE guidelines) Parent may decline to answer questions or provide information about family circumstances; declining does not prevent child from being enrolled if all other components are met. If parent is not able to read, the information must be conveyed in a different manner (MS 123.702,1b(a)).
(The Family Factors interview includes: Child Care and Education, Health Care, Family Resources and Needs.)

REFERRAL AND FOLLOW-UP

__ Ensure that an appropriate referral process is available (MS 123.702,2).
Three types are referrals are to be made: when there is a potential need or condition that requires further assessment; when the family lacks health care coverage; and referral to programs or services that maintain and enhance health and development. The first two types of referrals require followup contacts.

__ Notify the child's parents of a potential need or condition that requires assessment, diagnosis or treatment (MS 123.702,1b(a);2); all information must be made available to the parent (MR 3530.3700). Provide information about the names, agencies and providers to possibly be used for evaluation or diagnosis (MR 3530.3000,8). Referral criteria are included in the standards set by MDH or in the developmental screening instrument selected by the district.

__ If a child is without health coverage, refer the child to an appropriate health care provider (MS 123.702,1b(c)); include discussion of Children and Teen Checkups through Minnesota Care, Medical Assistance or other source of insurance and/or services.

__ Make referrals to programs and services that support the health and development of the child even when there is no identified problem. Health maintenance referrals are for periodic medical or dental examinations, immunizations or health or nutritional counseling (MR 3530.3000,4) and are to encourage parents to keep children connected with a health/medical "home" and receiving periodic well child care. Referrals may be made to Early Childhood Family Education and other early childhood programs in the community that enhance the child and family's growth and development. No followup contacts are necessary for these types of health maintenance and child development-enhancement referrals.

__ Diagnosis, treatment or therapy are not to be provided as a part of ECS although may be provided through other programs (MR 3530.4200).

__ Special education placement decisions, diagnostic conclusions and objectives for individualized education plans may not be based solely or primarily on screening data (MR 3530.4300).

__ Screening findings may be utilized in the first stage of development of the individualized service plan in the Learning Readiness initiative (MS 121.831,2;4(1)).

__ Screening findings may be utilized as one indicator in determining risk for the Early Childhood Family Education Home Visiting program (MS 121.882,2b(b)(1)).

__ Ensure that an appropriate follow-up process is available (MS 123.702,2).

__ The Learning Readiness program is a potential avenue for followup as listed in its program characteristics (MS 121.831, Subd. 4 - 1,4 & 6).

DATA/RECORDS

__ Provide the parent/guardian with a record of month and year the child received screening and of the results (MS 123.702,4a).

__ Obtain parent consent to disclose screening results to the school district (MS 123.704) for kindergarten enrollment (MS 123.702,1a).

__ The school district shall keep a duplicate copy of the record of each child screened (MS 123.702,4a) and information shall be incorporated into the school district record (MR 3530.3800), in the cumulative record or the pupil health record which is a part of the cumulative file. The summary report is to be kept as a permanent part of the record; detailed forms and information can be returned to the parent. Screening data not substantiated may not be part of school records as confirmed health/developmental problems (MR 3530.3800).

__ Establish a system for the school principal (or designee) to receive a record indicating the month/year screened and results (MS 123.702,1a). The record may be of ECS or a comparable screen by a health care provider (MS 123.702,1).

__ Send/receive records of children who transfer during kindergarten; allow 30 days for parent/guardian to submit records (MS 123.702,1a) during which time a child may attend school (MS 123.702,1a).

__ Annually submit a report summarizing the program and a request for aid payment (MR 3530.3200,6).

EARLY CHILDHOOD SCREENING
PLANNING - EVALUATING - REPORTING TOOL

This worksheet is a tool for school district personnel to evaluate their Early Childhood Screening (ECS) program. The areas for review follow those set in Minnesota Statute 123.74 for planning, evaluating and reporting educational programs. Although the law focuses specifically on curriculum, the steps outlined can be a guideline for ECS evaluation.

PLAN

The state law identifies the purpose of ECS and the law and rules set the parameters of the program.

In addition, each district implements the program according to the needs and values of its community as reflected in stated and unstated goals.

First identify the goals and the districts planning efforts to set these goals.
Then evaluate ECS using some of the questions suggested this plan.
Return to the goals and objectives to determine whether they are met or unmet.
Base goals and plans for the next year on your findings.

PURPOSE/GOALS:

The purpose of ECS as stated in statute is:

> [MS 123.701] Early detection of children's health and developmental problems can reduce their later need for costly care, minimize their physical and educational handicaps, and aid in their rehabilitation. The purpose of ECS is to assist parents and communities in improving the health of Minnesota children and in planning educational and health programs.

Through 15 years of conducting ECS, school districts and community agencies have designed and implemented programs to meet additional goals:

Provide a positive, validating, constructive experience for parents.
Provide a positive, engaging, and nonthreatening experience for children.
Demonstrate that school personnel are positive, sensitive, and responsive.
Set the stage for parental involvement in education.
Provide ideas and resources for parenting and developmental-enrichment.
Increase awareness of health, social and education programs in the school and community (ex. ECFE, MinnesotaCare).
Enable parents to become more aware of the connection between family circumstances and the child's development/learning.
Help families to access services and supports that meet family-identified needs and priorities.

ECS PER TOOL

PLAN: PURPOSE/GOALS: - continued

Requirements: Statement of Assurances on the back of the Annual Cost Report Form.

1. The parent of each child eligible for screening has been notified of the requirement for ECS.
2. All staff met the qualifications as defined in statute and rule.
3. All required screening components are offered in accordance with statute and rule.
4. The required screening services are offered at no direct cost to participating parents.
5. A referral and follow-up process is available.
6. No reimbursement request is submitted for children whose screening has been paid for by other agencies or for costs reimbursed by other sources.
7. No reimbursement is claimed for more than one screening per child.

___ **See also the green CHECKLIST FOR ECS PROGRAM-COORDINATING AND PLANNING**

Other Requirements:

Child Find for young children with special needs (federal special education law and regulations)
Community Social Services priorities (Mental Health Initiatives)
Community Public Health priorities (Maternal Child Health State/Local Initiatives)

___ **School District goals and objectives that are pertinent to ECS:**
(Review from the school district PER process, Community education, Parent Involvement)
1.
2.
3.
4.

___ **Goals and objectives for the district ECS program (stated and unstated):**
1.
2.
3.
4.

Planning Process Questions:

Who establishes the ECS goals and objectives?
Do a variety of school district educators have input?
What opportunity exists for input from referral resources and community members?

Are the goals communicated to school board members and administration?
Are the goals and objectives measurable?
Are annual goals based on evaluation of the previous years' program, incorporating changing community needs, values, and resources?

ECS PER TOOL

EVALUATE

***Structure*:** Characteristics of the school/agency and the personnel of ECS.

Who is the ECS Coordinator? Why?
Who are the members of the ECS team? Who are not members?
Do the team members participate in planning? In evaluation? In reporting?
Are the assignments of the team members clear? Acceptable? Reasonable?
How are team members informed of program changes, continuing education opportunities, and program results?

Who manages the budget? Why?
What do the ECS funds buy? Regular salary time? Extra time? Materials? Mileage?
By what process do team members share cost effective suggestions?
What additional funding sources are utilized? What linked services are used?

In terms of scheduling facilities, materials and staff, are there changes that would expedite the process?

Regarding the screening providers' knowledge and skills, how is initial training and annual review handled? Changes needed?

Do the screening tools help to answer your major questions/concerns about children's health and development? Or do they interfere with the process obtaining important information?

Do the tools measure what is intended to be measured (validity)?
Do they do so consistently (reliability)?

Process: Characteristics of the program in progress; mechanics of the program.

- **Outreach:**

  Which parents and children participate in ECS at the target age of 3 ½ - 4 years?
  Which do not? Why? How can non-participants be encouraged to attend?
  Which outreach efforts are effective? Most cost beneficial? Could be eliminated?
  Should be initiated?

- **Screening:**

  Registration:

  What occurs at registration from a child's viewpoint (eye level) and from a parent's viewpoint?

  What is the primary purpose of registration?
  Could some tasks occur later in the screening process?

ECS PER TOOL

EVALUATE: ***Process*** ■ **Screening** - continued

Screening Components: See the grid listing the screening components across the top and the questions on the side. For each component, ask the following questions:

How much time is required for each component? Is the time balanced with other components?
What are the providers' level of knowledge and skills? Strengths? Weaknesses? By what measure or criteria?
Logically and mechanically, how well do the standardized tools and/or the clinical tools work?
What is the quality/usefulness of the information obtained? What changes are needed?
How well are the children oriented to the component and environment before being screened?
Are the children comfortable interacting with the providers? Are the parents?
What opportunity do parents have to ask questions? Who answers parents' questions?

Parental Guidance/Health Promotion:
Are printed materials legible? At an appropriate reading level? In a reasonable amount?
When are printed materials discussed with parents? Why?
What visual information (posters, charts) is displayed? Audio-visual information presented?
Is the maximum amount of information provided without overload?
In what ways is information reinforced during the screening process? After screening?

Clinic Management:
What efforts are made to make parents and children feel welcome, oriented, involved?
Is assistance provided in moving from station to station?
How much "down time" is there for the child? For the parent?
Is the space adequate and does it allow for privacy as needed?
Are forms completed accurately and consistently?

■ **Referral and Follow-up:**

Referral:
Are findings explained to the parent in a way that is understood?
Do parents agree with the findings and indicate an intention to take action?
Is a range of resources offered for resolution or further assessment?

Confirming findings:
What methods are used to encourage assessment/evaluation of findings? Changes needed?
Do parents and providers return assessment/evaluation information to ECS? Why? Why not?
How much time and energy is spent on confirming findings? Is this adequate?
How can follow-up contacts be utilized to reinforce parental guidance information?
What system is used to keep track of the status of follow-up?

Data: Documenting and Communicating Data:
Who transfers information to the school intake staff person?
Who transfers ECS data to the Pupil Health Record? When? What information is transcribed? When are the long-form ECS records returned to parent or in another way purged from the cumulative record?
What information is included in records for children needing special education evaluation?
When are ECS data discussed with the kindergarten teacher, early educator, principal, school nurse or public health nurse, special educator?

ECS PER TOOL

BEST COPY AVAILABLE

EVALUATE: - continued

Outcome: Change in the child's health and developmental status, knowledge, skills, and attitudes.

What information is used to describe outcomes?

Discuss **output:**
- number and percent screened
- number and percent referred with identified problems by component

Discuss **outcome:**
- number and percent where follow-up is complete
- number confirmed, nature and resolution of concerns
- number referred to and participating in other programs for ongoing service
- number of kindergarten children entering school with concerns resolved
- increased knowledge of child development and community resources; improved parenting skills

Cost:	What are the total costs of the program (personnel, materials, energy, etc.)?
Cost benefit:	What are the costs as compared to the outputs, outcomes, community responses to the program goals?
Cost effectiveness:	What are the costs as compared to the outcomes - significant findings and resolution of problems (and resources saved because of the program) as stated in the program goals? What is the response from parents (the customers)? Educators? Health professionals? Is the program acceptable to the children/parents, educators, health care providers?

Summary:

What are the program's strengths and weaknesses?
What changes are needed?
What are the plans for improvement? Who is assigned to make changes?

ECS PER TOOL

REPORT

What ECS information is reported? To whom? When?
Does the report include school district goals, findings of the evaluation and plans for improvement?
How is information disseminated to school district educators, school district administration, community members, county officers, state legislators and state administrations?
Is there an invitation and opportunity for those receiving the information to respond?

December 1993, MDE/ECS/REL

ECS PER TOOL

ECS PER [Planning, Evaluating, Reporting] Grid
School Year _____

COMPONENT	REGISTRA-TION	GROWTH	SENSORY Vision	Hearing	DEVELOP-MENTAL	IMMUNIZA-TION REVIEW	HEALTH INFORM/ ACCESS	SUMMARY
TIME:								
Staff: Preparation Annual training								
Tool: Guidelines clear Effectiveness								
Environment: Privacy Noise Parent Observes								
Orientating child to each component								
Comfort: Child Parent								
Dialogue: Questions Feedback Information								

OTHER COMPONENTS	HEALTH HISTORY	NUTRITION REVIEW	FAMILY FACTORS	DENTAL	PHYSICAL ASSESSMENT	LAB TESTS	OTHER:	OTHER:
TIME:								
Staff: Preparation Annual training								
Tool: Guidelines clear Effectiveness								
Environment: Privacy Noise Parent Observes								
Orientation:								
Comfort: Child Parent								
Dialogue: Questions Feedback Information								

SAMPLE RADIO SPOTS FOR EARLY CHILDHOOD SCREENING

30-Second Spot

__(SCHOOL DISTRICT/AGENCY)__ INVITES ALL 3½ TO 4 YEAR OLDS TO EARLY CHILDHOOD SCREENING. EARLY CHILDHOOD SCREENING DETECTS HEALTH AND DEVELOPMENTAL PROBLEMS EARLY AND CONNECTS CHILDREN AND FAMILIES TO RESOURCES IN THE COMMUNITY THAT CAN HELP PROMOTE GROWTH, DEVELOPMENT AND HEALTH.

10-Second Spot

ALL CHILDREN NEED TO ATTEND EARLY CHILDHOOD SCREENING BEFORE KINDERGARTEN. IF YOU HAVE A 3½ TO 4 YEAR OLD CALL _____ FOR AN APPOINTMENT.

30-Second Spot

CHILDREN DON'T ALWAYS KNOW WHEN THEY'RE SICK. IN FACT, SOMETHING COULD BE WRONG WITH THEIR HEARING OR EYESIGHT AND YOU MIGHT NOT FIND OUT ABOUT IT. EARLY CHILDHOOD SCREENING DETECTS COMMON HEALTH PROBLEMS BEFORE THEY BECOME SERIOUS. IF YOUR CHILD IS THREE OR FOUR YEARS OLD, CALL _____ FOR AN APPOINTMENT OR INFORMATION. DON'T TAKE CHANCES WITH YOUR CHILD'S HEALTH.

10-Second Spot

YOUR CHILDREN ARE PRICELESS. PROTECT THEIR HEALTH, DEVELOPMENT, AND THEIR FUTURE. CALL FOR MORE INFORMATION ON MINNESOTA'S EARLY CHILDHOOD SCREENING PROGRAM, AT _____. IT'S WORTH IT!

10-Second Spot

A CHILD'S FUTURE COULD DEPEND ON HOW HEALTHY THE CHILD IS TODAY. HELPING YOUR CHILD GROW UP HEALTHY IS THE PURPOSE OF MINNESOTA'S EARLY CHILDHOOD SCREENING PROGRAM. CALL _____ FOR MORE INFORMATION.

SAMPLE PRESS SPOTS FOR EARLY CHILDHOOD SCREENING

School district name, address/phone number

Date of release: (or for immediate release)

Contact: (someone with additional information)

(Local school district) is sponsoring an Early Childhood screening program for preschool children.

Early Childhood Screening is a simple, careful check for vision, hearing, developmental and growth status, and an immunization review for three to four-year-old children. Participation in the screening is required before kindergarten entrance at no cost to parents. This screening program is not a substitute for a medical examination or ongoing family health care from a physician, dentist or other health provider.

The school district's Early Childhood Screening Program is designed to reach "healthy" children and find problems that can be corrected by early treatment. A Rand Corporation survey found ⅓ to ½ of the nation's blind and deaf children are needlessly handicapped. Many of these children could have been spared by early detection.

(Add a quotation from a school district or community official endorsing the program or commenting on the need for early detection of health problems.)

Parents are told at the screening if a health or developmental problem is discovered and referral recommendations are made. More than ½ of the children checked in previous Minnesota screening programs have needed further evaluation and treatment. Most of these referrals were for incomplete immunizations, speech and hearing problems, and dental needs.

Screening in (local community) will be done at (clinic site) on (date and times). For more information on Minnesota's screening programs, contact (school official) or the Minnesota Department of Health (612-623-5286) or Minnesota Department of Education (612-296-1398).

Family Information Sheet
EARLY CHILDHOOD SCREENING (ECS)

The purpose of this family information sheet is to talk with you about what is happening in your family. Many things can affect your child's growing and developing in positive ways, and some things may interfere with him or her being ready for school.

Please look at the questions and decide which ones you want to talk about at screening. You do not have to answer the questions or provide the information. If you choose not to, there will be no problem with your child being able to enroll in school. But we would like this chance to better understand and plan for your child. There are resources in the school and community to help you and your child get off to a good start.

This information is private. Only with your written consent will this sheet be shared with anyone or become part of your child's school record; otherwise it will be returned to you at screening.

Child's Name_____ Boy Girl Birthdate_____
(Circle One)

Home Address_____ School your child will attend _____

Parent's Name_____ Phone: day_____ evening_____
(& address if different)

Other Parent's Name_____ Phone: day_____ evening_____
(& address if different)

CHILD CARE AND EARLY EDUCATION

Who is most involved in your child's care?

Is your child
- __ at home with a parent or other family member most of the time
- __ in daycare/child care
- __ attending nursery school, preschool, Head Start, other_____
- __ involved in other early childhood/family education programs
- __ receiving any services for children with special needs?

HEALTH CARE

Physician/health care provider_____ Date of last health checkup_____

Address_____
Phone_____
(street, city/town)

Dentist_____ Date of last dental visit_____

Address_____
Phone_____
(street, city/town)

What kind of health insurance do you have?

__ No coverage at this time __ Private insurance __ Medical Assistance __MinnesotaCare

FAMILY INFORMATION: Please list family members, including adults and children, and others living in your home.

Name	Relationship to child	Highest grade completed	Birthdate	Male or Female

Please tell us about your family; for example, who lives in the child's home.

What do you see as the strengths of your family?

How would you describe the health of your child and your family?

Have there been any changes or problems in your family that might affect your child?
(examples - new brother or sister, a divorce, a death in the family, a move, financial problems, not enough food for the family)

We can help you find resources who may be able to help you in these areas:

for your child
- ___ communicating
- ___ learning
- ___ nutrition, eating
- ___ having fun with other children
- ___ challenging behaviors or emotions
- ___ other

for your family
- ___ meeting other families with children the same age
- ___ recreational programs
- ___ finding a parenting or support group
- ___ balancing work and family
- ___ help with personal family problems
- ___ adult reading programs, GED,etc.
- ___ jobs and training, career counseling

- ___ child care
- ___ transportation
- ___ clothing
- ___ food
- ___ public assistance
- ___ health or dental care
- ___ other_____

As you think about your child growing up in your family, please tell us some things that will help us better understand and plan for him or her. We will discuss some of these with you at screening.

Please describe how you see your child (what you like most, any concerns or needs).

What do you enjoy most about being a parent of your child?

Things about raising my child that are hard for me are

When I think ahead, I would like my child to

When I need help with my family, I

What else do you think would be helpful for others to know about your child or your family?

BALANCING RESOURCES AND NEEDS:

PLAN:

FOLLOWUP:

This information can be part of the school record Yes___ No___

Parent's Signature_____ Interviewer's Signature_____ Date_____

MDE/ECS/6-93 (telephone)

Summary
EARLY CHILDHOOD SCREENING (ECS)

Early Childhood Screening is a review of a child's health, vision and hearing and development to make sure he or she is on track and will be ready for school. The best age to screen children is 4 years old. Children enrolling in public school in Minnesota must be screened – see the required components below. The date and results of screening are required for school enrollment. Children may participate in the school screening program, or go to a private or public health care provider who offers a comparable program. This summary sheet becomes a part of the child's permanent school record.

Child's Name _____ SS# _____ Screening date ___/___/___
Birthdate ___/___/___
Age mos.____ yrs.____

OK
REscreen Screener's
Refer Initials

OPTIONAL COMPONENTS:

Physical assessment* _____ Last health checkup _____ _____

Dental inspection* _____ Last dental visit _____ _____

Laboratory tests* Hbg/Hct_____ Urine_____ Lead_____ _____ _____ _____

Health History/Current Health Status*
Past Health History _____ _____ _____
Present Health Status _____ _____ _____
Behaviors _____

Nutrition assessment* _____ _____ _____

Family Factors:
Child Care and Early Education _____ _____ _____
Health Care _____ _____ _____
Resources and Needs _____

REQUIRED COMPONENTS:

Immunization review - comments _____ (attach record) _____ _____

Growth Height _____(%tile) Weight _____(%tile) (attach graph) _____ _____

Vision Acuity R 10/____ L 10/____ (tool _____) _____ _____
rescreen R 10/____ L 10/____ Observation _____
Muscle balance _____

Hearing Screen R_____ L_____ (tool _____) _____ _____
rescreen R_____ L_____
_____

Development: (general findings, not scores) (tool _____) _____ _____
Cognitive_____
Fine/Gross Motor_____
Speech and Language_____
Social-Emotional_____

Parent Report of Development_____

COMMENTS: (birth verification)

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* If the child has been to a health care provider for a health checkup, request the records and summarize the findings here. These optional components may be offered at Early Childhood Screening but are not required for school enrollment.

SCREENING SUMMARY: (The child's strengths and needs may be recorded here.)

PRIORITIES: Plans/Recommendations/Resources/Timeline

Parent_____ Summary Interviewer_____

(telephone)

Copies: Parent School District (cumulative file or Pupil Health Record) Health Care Provider

FOLLOW UP:

EARLY CHILDHOOD SCREENING SURVEY

PARENT FEEDBACK: DATE:_____

1. How did you learn about this screening clinic? (check all that apply)

   ☐ friend/neighbor ☐ welfare department/social services

   ☐ newspaper ☐ Head Start ☐ physician

   ☐ school ☐ radio ☐ public health nursing service

   ☐ other (please list) _____

2. Was this screening clinic a good experience for you and your child?

   ☐ yes ☐ no ☐ undecided

   Any comments? _____

   _____

3. Do you feel better informed about your child's health and development in general after this clinic?

   ☐ yes ☐ no

4. As a result of this program, do you feel better informed about programs and services available to your child?

   ☐ yes ☐ no

5. As a result of this program were you or your child referred to any other programs or services?

   ☐ yes ☐ no

   If yes, please list:_____

6. Would you recommend this screening program to others?

   ☐ yes ☐ no ☐ undecided

7. Do you have any suggestions for improving this program?

☐ yes ☐ no

Please give your ideas: _____

PARENT CONSENT
EARLY CHILDHOOD SCREENING (ECS)

Name: _____ Record No. _____ Date: _____

Description of Program:

Early Childhood Screening is required for your child to enter school. Required components include:

1. A review of the immunizations your child has received to protect him/her from diptheria, pertussis (whooping cough), tetanus, polio, haemophilus influenzae, measles, mumps and rubella.
2. A developmental screening which reviews your child's thinking skills, large and small muscle skills, speech and language skills, social-emotional behavior and self-help skills, plus a review of your report on how your child is developing.
3. Hearing screening, which includes procedures to test for hearing problems.
4. Vision screening which includes testing for eye health, including how well your child can see.
5. A review of family information that may affect your child's development and ability to learn.

Optional screening components that <u>may</u> be offered are:

1. A health history including a review of the child's past and present health status, health practices and family health.
2. A nutrition assessment.
3. An unclothed physical assessment which includes measuring of pulse, respiration and blood pressure, an inspection of head, eyes, ears, nose, throat, neck, chest, heart, lungs, genitals, abdomen, spine, extremities, joints, muscle tone and skin.
4. A dental inspection which includes inspection of the child's mouth for any evidence of dental problems.
5. Laboratory tests which are appropriate to the child's age and health history may include the following:

   -urine tests for bacteria and other unusual substances, or for lead in the blood
   -sickle cell test to detect the presence of sickle cell trait or disease
   -blood test for other blood problems such as thalacemia
   -blood test for anemia

The components are for screening purposes and do not replace regular ongoing health care by a physician.

Participant's Rights, Obligations and Assurances:

1. The standards for the program are the same for everyone regardless of race, income, color, creed, national origin, political belief or sex.
2. The parent or guardian has the right to decline referral for evaluation, diagnosis and possible treatment for their child.
3. Refusal to participate in this screening or any of the components herein does not jeopardize Medical Assistance eligibility, or eligibility for other health or social service program. **Screening is required for school entrance.**

Authorization:

I hereby authorize the check up indicated below for _____
name of child

☐ Complete check-up as described, with the exception of the following component(s):

Signature	Relationship to child	Date
X _____	_____	_____

HE-01353-02 Rev. 10/91
140-0144

Minnesota Department of Health
Minnesota Department of Education

INFORMATION COLLECTION, USE AND RELEASE CONSENT
EARLY CHILDHOOD SCREENING (ECS)

Name of child _____	Record No. _____	Date _____

Information obtained in this screening is private and is available only to the child's parent(s) or guardian according to the Family Educational Rights and Privacy Act (1974). You are not required to release detailed information to anyone; however, a summary of the results of screening are required for your child to enroll in school. Private information and records cannot be discussed or released to anyone except as authorized by the parent(s) or guardian.

The information may be used by the school district to:

1. Facilitate counseling or other follow-up services which you may wish to obtain after the screening;
2. Transmit helpful information to another health, education or social services provider if a referral is made for further evaluation;
3. Permit evaluation of the screening program by the local school district, or the Minnesota Departments of Education and Health (for the latter purpose your child's identity remains anonymous);
4. Provide access to and accountability for government funds paid to the local school district for providing the required ECS services;
5. Plan for early childhood education programs and entrance to elementary school.

By signing this statement, I release the results of the screening to the school district to be used for permanent school health and developmental records.

In addition, I hereby authorize release of early childhood screening information to the following sources for purposes of evaluation, diagnosis, treatment and/or programming:

(Check any persons/agencies that you wish to receive information about your child's screening. Include name if checked.)

___ Physician (Name)_____
___ Dentist (Name)_____
___ Daycare center (Name)_____
___ Head Start (Name)_____
___ Early Childhood Family Education (ECFE)_____
___ Learning Readiness_____
___ Interagency Early Identification Committee (IEIC)_____
___ Other, please state_____
___ Only the school district.

Signature of parent/guardian	Relationship to child	Date
X _____	_____	_____

HE-01058-04 Rev. 10/91 MCHTS 140-0141

Minnesota Department of Health
Minnesota Department of Education

PHYSICIAN REQUEST FOR INFORMATION
EARLY CHILDHOOD SCREENING (ECS)

TO THE PHYSICIAN OR HEALTH CARE MEDICAL CLINIC: All school districts in Minnesota are required to offer developmental screening to each child at least once before entering kindergarten, (MN Statutes 123.701.707). The district must request information on physical exam, health history or laboratory tests completed within 12 months prior to screening these previous results. A parental release is enclosed for the child identified below. This information is defined by law as private and will be treated in accordance with the Data Privacy Act. Parents are informed that screening is not a substitute for a medical examination nor does it replace ongoing health care by a physician, dentist or other health care provider. Please complete this form and return it as soon as possible to the ECS program.

Child's Name _____	Birthdate _____	Date Examined _____

Pulse: _____ Respirations: _____ Blood Pressure: _____

Physical Assessment	No Significant Findings	One or More Significant Findings
Skin		
Head		
Face		
Neck		
Eyes		
Ears		
Nose		
Mouth		
Throat		
Chest		
Cardiovascular		
Lungs		
Abdomen		
Genitals		
Extremities		
Joints		
Muscle Tone		
Spine		
Neurologic Reaction		
Health and Developmental History Findings:		
Health History		
Present Health Status		
Health Behaviors/Practices		
Family Health		
Physical/Mental Health of Family Members Genetic/Inherited Diseases		

Laboratory Tests	Date	Results
1. Hemoglobin or Hematocrit		
2. Sickle Cell (If needed)		
3. Blood Lead (If needed)		
4. Urinalysis: Glucose		
Protein		
Ketones		
Bilirubin		
Blood		
Color		
pH		
5. Other		
Growth		
Height _____ in. _____ percentile		
Weight _____ lb. _____ percentile		

X _____ _____
Signature of Examiner Date

_____ _____
Address Phone

HE-01358-01 Rev. 11/91
140-0143

Minnesota Department of Health
Minnesota Department of Education

HEALTH HISTORY
EARLY CHILDHOOD SCREENING (ECS)

NOTE TO PARENTS, PLEASE READ AND SIGN:
The purpose of this health history is to help find any health problems your child may have. It will also give you a chance to ask questions or bring up any concerns. We will use it to get a general idea of how your child's health is right now and we can discuss ways to make it better in the future. We will look at where you get your child's health care and we will try to connect you with other services that you might need.
You do not have to give us the information asked in this form, but the more information we have, the better we can sum up your child's health needs and help you meet them.
This health history is classified as private and will not be released to anyone without your written consent. This form will be returned to you if you request it.
Participation in this screening program is voluntary and is not a requirement. Early Childhood Screening is not to be used instead of care by your regular doctor, nurse practitioner, dentist or other health care providers.

Sign here to show that you have read this note:

SIGNED X _____ Date _____

I. IDENTIFYING INFORMATION — Record # (for agency use only) _____

Child's Name (last, first, middle initial)	Sex (M,F)	Birthdate
Address		Home Phone
Parent's Name (and address if different)	Phone (Day)	Phone (Evening)
Other Parent's Name (and address if different)	Phone (Day)	Phone (Evening)
Date this form completed	Daycare Child Attends	School Child Will Attend

II. HEALTH CARE COVERAGE

PRIMARY PHYSICIAN	Physician's Name	Phone
	Address	Date of last complete health check-up
PRIMARY DENTIST	Dentist's Name	Phone
	Address	Date of last dental exam
HEALTH INSURANCE PLANS	Do you have health insurance? _____ Company/Policy # _____ Children's Health Plan # _____	
	Do you receive services from:	
	☐ Medical Assistance? If so, indicate MA # _____	
	☐ Public Health Nurse or EPS Agency?	
	☐ Other agencies? Please list: _____	

III. FAMILY INFORMATION

		Name	Birthdate	Sex (M,F)
LIST FAMILY MEMBERS	1.			
	2.			
	3.			
	4.			
	5.			
	6.			
LIST OTHERS LIVING IN YOUR HOME	1.	Name	Relationship	
	2.			

IV. IMMUNIZATIONS AND TESTS Give date (month, day, and year) for each of the following:

Type of Vaccine	1st Dose MO/DA/YR	2nd Dose MO/DA/YR	3rd Dose MO/DA/YR	4th Dose MO/DA/YR	5th Dose MO/DA/YR	6th Dose MO/DA/YR
DTP (Diptheria, Tetanus and Pertussis)						
POLIO						
MEASLES (Rubeola)						
GERMAN MEASLES (Rubella)						
MUMPS						
Haemophilus influenza (HIB)						
TB Testing						

BOLD area indicates the minimum number of doses which are required for school entrance.

The above information has been transferred from records maintained by the child's parent/guardian and indicates that the required number of doses of vaccine have been received.

X _____ _____
Signature of parent or legal guardian Date

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V. PAST HEALTH HISTORY (Check all ☑ that apply to your child.)

FAMILY HISTORY

1. ☐ Child is adopted. At what age?_____.
   ☐ I have no health information on my adopted child.

2. Have any of your child's blood relatives (parents, grandparents, aunts, uncles, brothers, sisters) ever had any of the following:
   ☐ Allergy or Hayfever ☐ Eye Abnormalities ☐ High Blood Pressure
   ☐ Asthma ☐ Diabetes ☐ Mental Disorders
   ☐ Cancer ☐ Epilepsy (Seizures) ☐ Mental Retardation
   ☐ Cleft Lip or Palate ☐ Heart Problems ☐ Rheumatic Fever
   ☐ Reading Problems ☐ Deafness ☐ Tuberculosis
   ☐ Growth Problems

   Explain: _____

   Inherited or family diseases:
   ☐ Thalassemia ☐ Hemophilia ☐ Sickle Cell Anemia ☐ Other Blood Disorders
   ☐ Cystic Fibrosis ☐ Muscular Dystrophy ☐ Other Family Diseases

3. Are there several family members who have had the same or similar physical/mental problems?_____

PREGNANCY

Mother had the following problems during pregnancy with this child:
☐ Rash, German measles ☐ Toxemia, high blood pressure, swollen ankles ☐ Diabetes
☐ Anemia ☐ Flu, infection ☐ Urinary tract infection
☐ Vaginal bleeding or infection ☐ Blood transfusions ☐ Rh incompatability
☐ Heart condition ☐ Seizures ☐ Depression
☐ Other, describe: _____
☐ Mother received x-rays or other treatments during this pregnancy. If yes, describe: _____
☐ Mother was hospitalized or had surgery. If yes, describe: _____

Mother used the following during this pregnancy. If yes, indicate which trimester(s).

	0-3 months	4-6 months	7-9 months
☐ Aspirin	☐	☐	☐
☐ Alcohol	☐	☐	☐
☐ Laxatives	☐	☐	☐
☐ Cigarettes	☐	☐	☐
☐ Street Drugs	☐	☐	☐
☐ Other, describe: _____	☐	☐	☐

BIRTH

When my child was born,
☐ There were difficulties during labor and/or delivery.
☐ My child had difficulties at birth or shortly after birth.
☐ My child weighed less than five pounds. Actual birth weight:_____ lbs. _____ oz.
☐ My child did not go home from the hospital with mother.

CHILDHOOD ILLNESSES

My child has had the following diseases:
☐ Meningitis ☐ Pneumonia ☐ Strep infections or scarlet fever
☐ Rheumatic fever ☐ Diabetes ☐ Chicken Pox
☐ Mumps ☐ "Red" or "Hard" measles (Rubeola) ☐ High fever (104° for longer than 2 days)
☐ German or 3-day measles (Rubella) ☐ Whooping cough (pertussis)
☐ Has had other serious illnesses for which he/she was *not* hospitalized. If so, describe:_____
☐ Has been hospitalized. If so, list dates, reason and treatment given:_____

ALLERGIES

My child has had the following problems:
☐ Asthma or hay fever ☐ Eczema or hives ☐ Severe reaction to insect stings
☐ Drug or medication allergy ☐ Food allergy ☐ Reaction to an immunization

INJURIES

☐ Has had one or more serious injuries (broken bones, stiches, strains or sprains). ☐ Has frequent injuries.
☐ Have syrup of ipecac on hand in your home and know when and how to use it. ☐ Has become poisoned.
☐ Have smoke detectors in place and working in your home. ☐ Always uses seatbelts or car seat when in the car.
☐ Uses safety equipment playing sports.

SPECIAL HEALTH NEEDS

My child:
☐ Has had special tests for health problems.
☐ Has been seen by medical specialists.
☐ Has had some chronic health problems. Please describe: _____
☐ Takes medication for a health problem.

GROWTH AND DEVELOPMENT

At what age did your child:
_____ Babble and coo _____ Walk
_____ Sit without support _____ Talk in sentences
_____ Stand without support _____ Become toilet trained

My child:
☐ is outgrowing clothes and shoes.
☐ cannot walk, talk, play as well as other children the same age.
Explain: _____

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VI. PRESENT HEALTH STATUS (Check all boxes ☑ that apply to your child.)

SKIN
- ☐ Has problems with rashes.
- ☐ Bruises easily.
- ☐ Has unexplained lumps or spots.

HEAD
- ☐ Has had one or more head injuries.
- ☐ Has had a period of unconsciousness as a result of an injury.
- ☐ Has headaches.

EYES
- ☐ Has problems with his/her eyes, such as squinting, crusty lids, mattering.
- ☐ Eyes cross or wander separately.
- ☐ Wears glasses or contact lenses.
- ☐ I have concerns about my child's vision.

Explain: _____

EAR, NOSE AND THROAT
- ☐ Has had ear problems two or three times within a year.
- ☐ Has had earaches or discharge from the ear within the past six months.
- ☐ Seems to have trouble hearing.
- ☐ Has had two or more throat infections in a year.
- ☐ Has frequent nose bleeds.
- ☐ Has swollen glands frequently.
- ☐ Has had ventilation (PE) tubes put in his/her ears or other treatment.

DENTAL

1. Source of water at home:
   ☐ city ☐ private well ☐ rural water system ☐ other ☐ don't know

2. Receives fluoride from any of the following sources:
   ☐ vitamins ☐ toothpaste ☐ tablets/drops ☐ mouth rinses ☐ dental office treatment

- ☐ Has trouble with teeth, gums, or mouth. Explain: _____
- ☐ Has teeth brushed daily or brushes own teeth daily.
- ☐ Has had dental sealants placed on one or more teeth.
- ☐ Has had a toothache.
- ☐ Has had teeth chipped or damaged in any way.

RESPIRATORY
- ☐ Has had 6-10 colds in a year.
- ☐ Has a severe cough with colds.
- ☐ Has trouble getting rid of cough or colds.
- ☐ Has shortness of breath, asthma or wheezing at times.
- ☐ Has been exposed to tuberculosis.

CARDIO-VASCULAR
- ☐ Hands and fingers turn blue.
- ☐ Has heart trouble.
- ☐ I have been told that my child has a heart murmur.
- ☐ Seems to tire easily.

GASTRO-INTESTINAL
- ☐ Vomits frequently.
- ☐ Has frequent stomach aches.
- ☐ Seems to have a problem with foods disagreeing with him/her.
- ☐ Has diarrhea frequently.
- ☐ Has bloody stools.
- ☐ Has trouble with constipation.
- ☐ Has anal itching.

URINARY
- ☐ Is not toilet trained.
- ☐ Has trouble with bedwetting.
- ☐ Has trouble wetting during the day.
- ☐ Has had a kidney or bladder infection.

SKELETAL
- ☐ Complains of pains in his/her arms, legs, back or joints.
- ☐ Limps, toes in or toes out.
- ☐ Has had a broken bone, cast, brace or corrective shoes.

NEURO MUSCULAR
- ☐ Loses his/her balance in unusual ways.
- ☐ Has some unexplained movements or jerks.
- ☐ Has had convulsions or seizures.
- ☐ Has a weakness in his/her body.
- ☐ Has staring spells.
- ☐ Seems to fall down more than other children.
- ☐ Is clumsy and awkward.

SPECIAL CONCERNS

List any medications your child takes regularly: _____

Describe any physical limitations or restrictions your child has: _____

Describe any concerns you have about your child. _____

VII. LEAD (Check all boxes ☑ that apply to your child.)

- ☐ Chews unusual things (such as woodwork, pencils, paint chips, crib plaster, paper, cigarettes, clay or soil).
- ☐ Has a sibling or playmate with lead toxicity.
- ☐ Lives or visits regularly in a house built before 1950.
- ☐ Lives adjacent to a heavy traffic area or a lead-related industry.
- ☐ Has a member of the household who works in a lead industry (such as automobile batteries, lead piping, etc.).
- ☐ Plays on grounds or lives near a heavy traffic area, hazardous waste site, lead smelter, processing plant, or where old buildings have been demolished and filled.
- ☐ Has used folk medicines.

VIII. BEHAVIOR (Check all boxes ☑ that concern you about your child.)

Does your child:
- ☐ Cry easily and often
- ☐ Anger easily
- ☐ Get overly excited
- ☐ Follow adult direction
- ☐ Act without thinking
- ☐ Use imagination in play
- ☐ Break or destroy things
- ☐ Have problem habits that are hard for him/her to break or control (i.e. bedwetting, thumbsucking, nailbiting)
- ☐ Take things that do not belong to him/her
- ☐ Ask for help when frustrated
- ☐ Play well with others

Are your child's feelings easily hurt? ☐ yes ☐ no

How does your child show displeasure? _____

How does your child show happiness? _____

Can your child:
- ☐ Be soothed and calmed when upset
- ☐ Play or work independently

Is your child:
- ☐ Restless
- ☐ Tired a lot
- ☐ Over-active
- ☐ Overly cautious, fearful, shy
- ☐ Usually happy and playful
- ☐ Often irritable or disobedient
- ☐ Moody
- ☐ Cruel to animals or other children
- ☐ Withdrawn or overly aggressive

☐ I have concerns about some of my child's behaviors. Explain: _____

IX. NUTRITION (Check all boxes ☑ that apply to your child)

How many glasses/bottles or total ounces of milk does your child drink in 24 hours? _____ ☐ 4 oz. glass/bottle ☐ 8 oz. glass/bottle other _____

What kind of milk/formula? ☐ cow ☐ goat ☐ soy ☐ infant formula with iron ☐ infant formula without iron ☐ breast

If milk is it fortified with vitamins A and D? ☐ yes ☐ no

Is the milk: ☐ whole milk ☐ 2% ☐ 1% ☐ skim

What breakfast cereals does your child normally eat? _____

What fruits and vegetables does your child eat? _____

Does your child take vitamins or mineral supplements? ☐ yes ☐ no

Which ones? _____ How often or how much? _____

How many ounces of meat or meat substitute (i.e. beans, lentils) does your child get in an average day? _____

Are there foods your child cannot or will not eat? ☐ yes ☐ no Which ones? _____

What does your child drink as a thirst-quencher? ☐ water ☐ apple juice ☐ kool-aid ☐ pop other _____

Is your child always thirsty? ☐ yes ☐ no

Do you think your child has a poor appetite? ☐ yes ☐ no

Does your child eat a special diet? ☐ yes ☐ no If yes, explain _____

Does your child drink from a bottle? ☐ yes ☐ no

FOOD FREQUENCY

DIRECTIONS: In each of the food groups listed below, circle the foods most often eaten by your child. Check (☑) the box to the right that most closely describes how often these foods are eaten.

FOODS		NUMBER OF TIMES EATEN					
		Never	Less than once per month	1-2 times per week	3-6 times per week	Daily	More than once per day
I	Milk, cheese, yogurt, cottage cheese, ice cream, pudding, infant formula, breast milk						
IIA	Carrots, broccoli, squash, greens (spinach, swiss chard, kale, mustard, turnip) pumpkin, sweet potatoes, apricots, peaches, watermelon, prunes, cantaloupe						
IIB	Other fruits and vegetables or their juices not listed above or below, infant/toddler mixed dinners						
IIC	Oranges, orange juice, grapefruit, grapefruit juice, strawberries, broccoli, tomato, tomato juice, baked potato, cabbage, cole slaw, infant/toddler juice						
IIIA	Beef, hamburger, pork, liver, lamb						
IIIB	Chicken, turkey, fish, tuna, eggs						
IIIC	Dried peas, lentils, peanut butter, nuts, tofu, dried beans - either alone or in mixed dishes such as chili						
IIID	Sausage, bacon, hot dogs, lunch meat, cold cuts, infant meat sticks						
IV	Bread, rice, cereal, pasta, noodles, rolls, muffins, tortillas, biscuits, pancakes, waffles, bagels, lefse, infant cereal						
VA	Butter, margarine, oil, lard						
VB	Pop, soda, kool-aid, Hi-C, fruit drinks, coffee, diet pop, tonic, iced tea						
VC	Pies, cookies, cake, donuts, sweet rolls, candy, infant/toddler fruit desserts, teething biscuits						
VC	Fried meats, french fries, fried chicken, fried fish						

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Student Health Data - Authority

Pupil Health Record	Minnesota Statute 144.29
Early Childhood Screening	Minnesota Statute 123.701, Minnesota Rule 3530.3800
Immunization Requirements	Minnesota Statute 123.70
Family Educational Rights and Privacy Act (FERPA)	Federal Law - 20 USC 1232g Federal Regulations 45 CFR Part 99
Government Data Practices	Minnesota Statute (MS) 13.02-38, Minnesota Rules

Components of the Pupil Health Record

The pupil health record has five components as listed below in the chart. The format for the record in Minnesota is an 8 in.-by-11 in. folder with spaces for direct documentation the folder format for accumulation of pertinent information not transcribed in total directly, but referenced, on the record. The old single card format does not allow adequate space or organization for the necessary components.

Federal and state requirements specify certain types of information to be recorded on the record; these are cited below in the authority column. Other categories of pertinent information are listed; these are derived from school nursing practice and are comparable to components of records in health/medical settings and other educational records. Special education records. (See Wold, 1981, for further discussion.)

Components	Authority
PUPIL CENSUS DATA, DIRECTORY INFORMATION Emergency information Family information, data concerning parents	20 USC 1232g (a)(5)(A) 45 CFR 99.3 MS 13.32 Sub. 2
ACCURATE, COMPLETE AND CURRENT DATA BASE Past health history Present health status Immunization status Review of systems Findings from vision, hearing, growth and other assessments Health practices Developmental history and status Family structure, function and health	MS 13.05 Sub.5 MN Rule 3530.3400, .3800 MN 13.32 Sub.2; MS 123.70 MS 149.29 MN Rule 3530.3400, .3800
PROBLEM/CONCERN LIST (For ECS data, only confirmed problems may be incorporated into the record as confirmed health or developmental problems.)	MS 13.32 Sub.2, MS 144.29 MN Rule 3530.3800
SEQUENTIAL NARRATIVE NOTES (SCHOOL NURSE NOTES)	MS 13.32 Sub. 2
PLAN FOR CONTINUITY OF CARE/SERVICE AT TRANSFER, GRADUATION	

Adapted from Wold, S. School Nursing, A Framework for Practice. North Branch, MN: Sunrise River Press, 1981.

PUPIL HEALTH RECORD

Minnesota law requires that each student have a permanent pupil health record and outlines the components and use of the record. Also federal and other state mandates offer guidelines for use and dissemination of educational data, including student health information.

Principles that apply to other student records also apply to the pupil health record. First, student records become an exercise in record keeping and paper work unless used by students and their educators. Educational records serve as benchmarks of progress and potential, specify factors that may interfere with learning and therefore require a unique educational program, outline successful teaching/learning methods and other interventions, and are tools in problem solving. The second essential principle is that data must be accurate and complete, and information interpreted and applied accurately and completely. The multidisciplinary educational team, working with parents and students, offers a system of checks and balances to appropriate use of data and also strengthens sound educational programs.

PURPOSE OF THE PUPIL HEALTH RECORD

To Document

- Identify and seek remedies for health problems that may interfere with learning.
- Organize material and the approach to children's health into a systematic and retrievable format.
- Establish a legal record of problems identified and services provided; record the practice of health professionals and educators.
- Provide a vehicle for continuity of care and service.

To Communicate

- Inform the educational team members of student strengths and limitation, actual and potential areas of need, special services required, areas where adaptation of education is required, areas where adaptation of the environment is required, successful and unsuccessful management strategies.
- Assist the student in gaining knowledge and skills about a specific problem or concern and about the decision making process.
- Relate to parents the school's response to the child and his/her special needs.
- Report progress of treatment/management plans to the primary health care provider and others meeting a student's complex needs.
- Provide a data base in the event of an emergency.

Minnesota Statute 144.29 HEALTH RECORDS; CHILDREN OF SCHOOL AGE.

It shall be the duty of every school nurse, school physician, school attendance officer, superintendent of schools, principal, teacher, and of the persons charged with duty of compiling and keeping the school census records, to cause a permanent public health record to be kept for each child of school age. Such record shall be kept in such form that it may be transferred with the child to any school which the child shall attend within the state and transferred to the commissioner when the child ceases to attend school. It shall contain a record of such health matters as shall be prescribed by the commissioner, and of all mental and physical defects and handicaps which might permanently cripple or handicap the child. Nothing in sections 144.29 to 144.32 shall be construed to require any child whose parent or guardian objects in writing thereto to undergo a physical or medical examination or treatment. A copy shall be forwarded to the proper department of any state to which the child shall remove. Each district shall assign a teacher, school nurse, or other professional person to review, at the beginning of each school year, the health record of all pupils under the assignee's direction. Growth, results of vision and hearing screening, and findings obtained from health assessments must be entered periodically on the pupil's health record. History: 1993 c 224 art 12 s 30

RECORD MANAGEMENT INCLUDING DATA PRIVACY

School district management of information is guided by federal and state requirements and by district policy. Each district needs a written policy for appropriate handling of educational data, including student health data. The pupil health record is considered part of the student cumulative file and is to be handled in the same manner as other records while the student is enrolled and when he/she leaves the district for transfer, graduation, or the like.

CLASSIFICATION	
Educational data	MS 13.32 Sub.1a
Student health data are educational data	MS 13.32 Sub. 2
Private data	MS 13.02 Sub. 12
Health data are private data	MS 13.38
Educational data are private data	MS 13.32 Sub. 3
HANDLING	
Appropriate security safeguards	MS 13.05 Sub. 5
REVIEW	
Annual review and recording of pertinent data	MS 144.29
Current data	MS 13.05 Sub. 5
DISSEMINATION	
Provide parent/guardian with a record of month and year the child received screening and of the results	MS 123.702 Sub. 1a
Obtain parent consent to disclose screening results to the school district for kindergarten enrollment	MS 123.704 MS 123.702 Sub. 1a
School district shall keep a copy of the record of each child screened	MS 123.702 Sub. 4a
Incorporate ESC records into the school record	
Screening data not substantiated may not be part of school records as confirmed health/developmental problems	MR 3530.3800 MR 3530.3800
Prior consent for disclosure required	45 CFR 99.30: MS 13.05 Sub. 4d
May share data with educators in the district	
Disclose data in health and safety emergencies and for epidemiological studies	45 CFR 99.31; MS 13.32 Sub.1
May withhold certain data from parents if requested by a minor if determined to be in student's best interest	20 USC 1232g(b)(1)(I); 45 CFR 99.3; MS 13.32 Sub. 3d,f
Maintain a permanent record of disclosures	MS 13.02 Sub. 8 45 CFR 99.13.32
CLOSING RECORDS, DESTROYING DATA	
Follow district policy regarding permanent, private educational data	
ECS data, immunization record, problem/concern list, school nurse notes, screening and assessment data	
If data are transcribed, not source, transcriber and data; return original data to student/parents for family records	
Send record when student transfers within school district or state without release of information	MS 144.29 45 CFR 99.31
If family moves out of district or state, consider retaining a copy of records until statutes of limitations expire	

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NAME

PUPIL HEALTH RECORD

(in pen; both parents' names if both at home)
PARENTS' OR GUARDIAN(S) NAME

(in pencil)
ADDRESS

(may include work address & phone in pencil)
PHONE

(in pencil)
PHYSICIAN — PHONE

DENTIST — PHONE

(may list other providers: specialists, case worker, public health nurse - in pencil)

STUDENT NO. — SEX — BIRTHDATE

	PS	K	1	2	3	4	5	6	7	8	9	10	11	12
HEALTH CLASSIFICATION*	List health classification as specified by physician. If none listed, do not presume. Explain all II below.													
PROBLEM 1/HEALTH MAINT.	Check box for appropriate year when all Health Main. items are complete for that year as recommended. Not all items are necessary annually. Or may use code: ME = Med. Exam, I = Immunization, etc.													
MED. EXAM														
HEALTH SCREENING														
IMMUNIZATIONS														
DENTAL EXAM/RX														
OTHER														

* HEALTH CLASSIFICATION I = FULL ACTIVITY
HEALTH CLASSIFICATION II = RESTRICTED ACTIVITY

	PROBLEM LIST	DATE IDENTIFIED	DATE RESOLVED
2	Medical Diagnosis, Nursing Diagnosis, Educational Assessment, Social Concerns.		
3			
4	State the problem at the highest level of refinement known. Include name of person identifying the problem (physician, school nurse, educator, parent, student).		
5			
6		First recognition of problem in school.	
7			
8		Date of resolution is based on the health professional's judgement.	
9			
10			
11			
12			
13			

	PROBLEM LIST	DATE IDENTIFIED	DATE RESOLVED
14			
15			
16			
17			
18			
19			
20			
21	ADDRESS FOR PURCHASE OF PHR:		
22	Walter S. Booth		
23	716 Main Street North Branch, MN 55056		
24	1-800-245-5835 or 612/674-4413 FAX 612/674-4412		
25			

ECS - Appendix E-4

Walter S. Booth Co. — North Branch, MN

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NAME _____ STUDENT NO. _____

SCHOOL HEALTH SCREENING AND FOLLOW-UP RECORD

GRADE	DATE	VISION									HEARING			SCOLIOSIS			OTHER
		ACUITY		WITH GLASSES	TEST / tool	M/B*		COLOR		COMMENTS	R	L	COMMENTS	P	R	COMMENTS	
		R	L			P	R	P	F								
				or other corrective lenses													Blood pressure
																	Nutrition
																	Dental
																	Development
				144											145		

NAME _____ STUDENT NO _____

NARRATIVE NOTES

DATE	PROBLEM NUMBER & PROBLEM	FINDINGS (SUBJECTIVE & OBJECTIVE)	ASSESSMENT & PLAN (SIGN EACH ENTRY)
	# and problem from list, may list a related subproblem.		Assessment (A): According to the health professional's judgement and perception,
		Subjective data (S): What does the student & family think	what is happening? What are the concerns? resulting impact?
		and say?	Plan (P): What are the desired outcomes?
		Objective data (O): What is observed, measured, reported?	What action will be taken? by whom? when? how? What behaviors will be measured?
		What are the pertinent norms and standards?	Implementation (I): Who is carrying out the plan?
			What progress can be noted? Evaluation:
			Have desired outcomes been achieved according to the set criteria?
			Signature and title/position (legal record)
	Health maintenance data (Early Childhood Screening summary, physical assessment findings) may be recorded in block format rather than problem-solving-process (SOAP-IE) as above.		
	List the problem as #1 Health Maintenance (list item in parenthesis - ECS Summary). Transcribe pertinent data. Well-child results are as important to note as problems. Be specific, including measurement and instruments or tools used (Developmental screening - DIAL: within normal range for age). State source, person preparing original report. Signature of transcriber/position/date.		
	If data on original report is extensive, the report may be permanently attached to the PHR. Note the problem number and name the report refers to, topic of report, data and source of report in the PHR.		

	INSERTS:		
	Immunization Record		
	Stature and Weight Grids		
	Pertinent reports		
	Extensive health history for students with chronic conditions		
	Medication and treatment permission statements and administration chart or calendar		

NAME _____ STUDENT NO. _____

NAME

PUPIL HEALTH RECORD

STUDENT NO. SEX BIRTHDATE

PARENTS' OR GUARDIAN(S) NAME

ADDRESS

PHONE

PHYSICIAN PHONE

DENTIST PHONE

	PS	K	1	2	3	4	5	6	7	8	9	10	11	12
HEALTH CLASSIFICATION*														
PROBLEM 1/HEALTH MAINT. – MED. EXAM – HEALTH SCREENING – IMMUNIZATIONS – DENTAL EXAM/RX – OTHER														

* HEALTH CLASSIFICATION I - FULL ACTIVITY
HEALTH CLASSIFICATION II - RESTRICTED ACTIVITY

PROBLEM LIST	DATE IDENTIFIED	DATE RESOLVED	PROBLEM LIST	DATE IDENTIFIED	DATE RESOLVED
2			14		
3			15		
4			16		
5			17		
6			18		
7			19		
8			20		
9			21		
10			22		
11			23		
12			24		
13			25		

Walter S. Booth Co. - [illegible]th Branch, MN

NAME _____ STUDENT NO. _____

SCHOOL HEALTH SCREENING AND FOLLOW-UP RECORD

GRADE	DATE	VISION									HEARING			SCOLIOSIS			OTHER
		ACUITY		WITH GLASSES	TEST	M/B*		COLOR		COMMENTS	R	L	COMMENTS	P	R	COMMENTS	
		R	L			P	R	P	F								

NAME _____ STUDENT NO. _____

NARRATIVE NOTES

DATE	PROBLEM NUMBER & PROBLEM	FINDINGS (SUBJECTIVE & OBJECTIVE)	ASSESSMENT & PLAN (SIGN EACH ENTRY)

MDE Minnesota Department of Education	Children and Families 986 Capitol Square - 550 Cedar St. Paul, MN 55101-2273	EARLY CHILDHOOD SCREENING COMPLETION REPORT AND REQUEST FOR REIMBURSEMENT	ED-01611-15 DUE: Aug. 15

GENERAL INFORMATION AND INSTRUCTIONS: The reporting of your annual Early Childhood Screening (ECS) program and component cost is required by M.S. 123.701-123.7045 and Minnesota Rule 3530.3200. The information assists in planning educational and health programs for children. Please print or type the information requested and record any comments on the back of this form. Retain a copy for your files, and return one copy at the completion of your program but **not later than August 15, 1995.**

IDENTIFICATION INFORMATION

District Name	District Number	County Name

Name of Agency Coordinating the Screening Program (if different from above)

Name of Early Childhood Screening Coordinator	Title/Position	Telephone Number	FAX Number
		( ) -	( ) -

GENERAL INFORMATION

(1) Number of Children Eligible for 1994-1995 ECS Program	(2) Number of Children Screened Prior to Kindergarten at the Following Ages:				(3) Number of Kindergarten Children Screened in a "CATCH-UP" Program	(4) TOTAL NUMBER SCREENED Sum of Col. (2) and Col. (3)	(5) Number of 1994 Entering Kindergartners Screened Through Other Sources	(6) NUMBER ENTERING KINDERGARTEN WITH NO SCREENING (Parent Exemption)
	2	3	4	5			Private Health Care Provider . . . . . _____ Public Health Agency . _____ Headstart . . . . . _____ Other . . . . . _____	

FREQUENCY OF ECS OFFERING

Check (X) how often during the school year ECS is offered:

[ ] Monthly [ ] Quarterly [ ] Annually [ ] Other (specify): _____

DEVELOPMENTAL SCREENING INSTRUMENT

Instrument and Parent Report Used:

PERSONNEL AND COST INFORMATION

In this table, use a screening agency code number to identify the personnel who provide each screening component. Indicate the number of children participating in each component. Provide the total program costs for each screening component.

SCREENING AGENCY CODES

1 - Local School District
2 - Cooperative or ECSU
3 - Medical Clinic
4 - Public Health Agency
5 - Private Contractor
6 - Community Resource

PERSONNEL CLASSIFICATION CODES

SN - School Nurse (Licensed)
PHN - Public Health Nurse
PHY - Physician
VOL - Volunteers
SPE - Special Education Staff
ECFE - Early Childhood Fam. Ed / Learning Readiness
OTH - Other

SCREENING PROGRAM	ENTER SCREENING AGENCY CODES OF PERSONNEL PROVIDING SCREENING								NUMBER OF CHILDREN BY COMPONENT	TOTAL COST BY PROGRAM COMPONENT
	SN	PHN	PHY	VOL	SPE	ECFE	OTH → Specify Below			
Outreach										$
REQUIRED COMPONENTS: Vision and Hearing										
Developmental										
Height and Weight										
Immunization Review										
Summary Review with Parents										
Other (Specify):										
Follow Up										
Administration (Coordinator and Clerical Staff) Specify: _____										
Other (Travel, Materials, Rent) Specify: _____										
TOTAL ACTUAL COSTS FOR REQUIRED COMPONENTS OF ECS →										$
1994-95 AID ENTITLEMENT (Required Components ONLY): $25.00 X _____ (Children Screened from Item #4 above)										$ *

* Use UFARS Finance Dimension Code #354

COMPLETE REVERSE SIDE AND PROVIDE VERIFICATION SIGNATURES →

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Follow the directions on the front of this form to provide the information requested below.

SCREENING AGENCY CODES		PERSONNEL CLASSIFICATION CODES		
1 - Local School District	4 - Public Health Agency	SN - School Nurse (Licensed)	VOL - Volunteers	OTH - Other
2 - Cooperative or ECSU	5 - Private Contractor	PHN - Public Health Nurse	SPE - Special Education Staff	
3 - Medical Clinic	6 - Community Resource	PHY - Physician	ECFE - Early Childhood Fam. Ed / Learning Readiness	

SCREENING PROGRAM	ENTER SCREENING AGENCY CODES OF PERSONNEL PROVIDING SCREENING								NUMBER OF CHILDREN BY COMPONENT	TOTAL COST BY PROGRAM COMPONENT
	SN	PHN	PHY	VOL	SPE	ECFE	OTH →	Specify Below		
• OPTIONAL COMPONENTS										
Family Factors										
Health History										
Physical Inspection										
Laboratory Tests										
Dental										
Nutrition Assessment										
Other (Specify):										
TOTAL ACTUAL COSTS FOR OPTIONAL COMPONENTS OF ECS →										$

SUPPLEMENTAL FUNDING SOURCES

Check (X) those sources of funding which were used to supplement state revenues for Required Components and/or Optional Components and record the amounts in the spaces provided.

	REQUIRED COMPONENTS	OPTIONAL COMPONENTS
[ ] General Education Basic Revenue (Foundation Aid)/General Fund (Fund 1) .	$	$
[ ] Early Childhood Family Education (ECFE) (Fund 4)	$	$
[ ] Learning Readiness (Fund 4)	$	$
[ ] Special Education	$	$
[ ] Voluntary Services / Agencies (Specify): _____	$	$
[ ] Public Health Resources	$	$
[ ] Other (Specify): _____	$	$
[ ] A fee was charged to parents for Optional Screening in the amount of $_____. Total fees collected were ▶		$

OPTIONAL SUMMARIES

Please attach short summaries described below. These summaries are OPTIONAL. The information will assist in describing Early Childhood Screening to policy makers.

1. PARENT RESPONSE TO SCREENING: Include components from parents such as feedback on screening being a requirement for school enrollment, the family factors component, and general satisfaction.
2. PROGRAM FINDINGS: Include information such as the number or percent of findings and referrals by component, any significant or unusual findings for a child, the success of links to learning readiness or other early childhood program and community resources.

VERIFICATION OF DATA AND STATEMENT OF ASSURANCES

It is hereby verified that the above information is true and correct, and is in compliance with the provisions of M.S., Section 123.701-7045, and Minnesota Rules, Parts 3530.3000-.4310, as follows:

1. The parent of each child eligible for screening has been notified of the requirement for Early Childhood Screening.
2. All staff have met the qualifications as defined in M. S. 123.702, Subd. 4 and Minnesota Rules, Part 3530.3400.
3. All required screening components have been offered in accordance with M.S. 123.702, Subd. 1b(a) and Minnesota Rules, Part 3530.3400.
4. The required screening services have been offered at no direct cost to the participating parents.
5. A referral and follow-up process is in place.
6. No reimbursement request has been submitted for children whose screening has been paid for by other agencies or for costs reimbursed by other sources.
7. No reimbursement has been claimed for more than one screening per child.

_____ _____
Signature - Clerk, School Board Date

_____ _____
Signature - Superintendent / Responsible Authority Date

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INSTRUCTIONS FOR COMPLETING
ECS COMPLETION REPORT AND REQUEST FOR REIMBURSEMENT
1994-95

March 1995

PRINCIPLES

- The state budget for ECS is based on the numbers in this report.
- Please calculate ACTUAL COSTS. Please include not only your direct expenditure but also your in-kind costs. What ECS really costs - not how much are you reimbursed.
- Please do not LUMP component costs. YOUR best estimate is 100 times better than our wild guess.
- Please separate costs for OUTREACH and FOLLOW-UP from ADMINISTRATION. No cost? Do I assume no outreach or follow-up was done?
- Narrative reports are welcome -- such as a summary of parent responses. Any feedback on Family Factors and links to Learning Readiness would be most helpful. See the note on the back of the report form requesting optional summaries.

DETAILS

Due date is August 15. We welcome reports anytime in May or June.

Identification Information

Remember -- the person listed gets the mail. Superintendents are usually sent a brief information sheet only once a year on ECS. So share the information you receive with him/her and people in your early childhood network! Add your FAX number if it is handy - otherwise optional.

General Information

(1) Number of Children Eligible. The number of eligible children is based on the number of children in a given age group. This is the number of children planning to enter kindergarten a year from now (if you are screening 3 1/2 to 4 year olds). Remember to include homeless or other high-risk children in your estimate. The number will fluctuate from year to year according to birth rate and family mobility.

(2) Number of Children Screened Prior to Kindergarten by Age. These are the children in your regular ECS program. The goal is to screen earlier ages so children are seen a full year prior to school entrance.

The rate (percent) of ECS eligible children screened is the comparison of eligible children (1) to number screened (the sum of the number in (2).)

(3) Number of Kindergarten Children Screened. This number represents children who enrolled in school and had 30 days to comply with the mandate for screening. If the total amount of funds requested statewide exceeds the amount allotted, the reimbursement for the children at this kindergarten age will be prorated, not the total number of children screened.

(4) The Total Number Screened is the sum of (2) and (3). This number will be used on the bottom line of the front page to calculate your district's reimbursement. You may request full reimbursement for the kindergarten catch-up children as well as the regular ECS children.

(5) Estimate the Number of Children Screened Through Other Sources.

Please note that we expect this number to rise as you make links with service providers in your communities. In our budget estimates for 1994-95, we assumed that a minimum of 5% of children will be screened from another source. As children get better access to preventive health care, more and more children should be screened by health care provider that offer a comparable screening, and then records transferred to school.

Program Implementation

Check how often you hold screening. Please name the developmental screening tool you use: Dial-R, Denver II, Minneapolis, etc.

Personnel and Cost Information

Please enter personnel conducting screening by component. Use the codes to indicate which agency employs the staff. This documents the inter-disciplinary nature of ECS and the interagency cooperation.

List number of children screened by component. Most likely all children will be screened in all components. Note that height and weight has been added as a required component.

For the Follow-up line, indicate the number of families that need to be contacted to ensure the children reached their referral sources (does not include recommendations for routine well-child exam or dental visit, or referral to ECFE; does included referral for a noted health problem, if immunizations are behind or referral if the family does not have a health provider, referral to ECFE if specific child development or support for parents is needed, referral to the IEIC for special education assessment, etc.) A range of 20 - 50 % of children often need followup. This is the only measure of OUTPUT (how many problems noted) that we have for ECS.

For required components (front side) and optional components (back), calculate costs based on your regular ECS program (not including the kindergarten program). You can lump your cost for the Kindergarten program and include on the linemarked OTHER, labeling it Kindergartners.

Calculating cost by component requires setting up formulas such as:

a) [Number of staff] x {Salary (in hours or days, including training time) and fringe] x [Time (in hours or days)] + materials) = TOTAL cost by component

If one staff conducts more than one component, please estimate the portion of time spent in each; split the cost according to that portion of time.

or

b) [Charge (per child) from another agency] x [Number of children screened] = TOTAL COST by component.

When contracting with other agencies, please include in your contract language that they will provide you with information on cost by component and their method of calculation.

ZEROS?? No cost? I assume the component (ex. outreach, follow-up) was not done. There is a cost for every component. Even volunteers for screening do not come free because they need to be trained, supervised on site, and positive findings rescreened prior to referral.

Summary Reports

The movement in all education is to measure customer/parent satisfaction and learner/student outcomes. Please provide any summary information you have readily available - such as a report to your school board or county health service board, the summary of numbers from your follow-up tracking sheets, etc. This annual report contains outputs (how many children come); now we need outcomes (so what? what happened?) Your summaries this year will provide a guide for a request for outcomes next year.

Supplemental Funding Sources

The reimbursement rate at $25 per child may or may not cover the costs of this partial screening program. The program costs is higher in most districts. In this section, please indicate ways in which other education programs and community programs support ECS through direct payment or in-kind contributions.

Note that the sum of the Supplemental Funding sources for required components plus the Aid Entitlement (front page-last line) should equal the Total Actual Costs for Required components (front page). The Supplemental Funding Sources for optional components should equal the Total Actual Costs for Optional Components (back page).

Verification

This section verifies the report is accurate. And it is also confirmation that the program has been implemented according to state statute and rule.

Make a copy. Send it in!!

MANY THANKS!!

MDE/ECS/rel/3-95

MDE Minnesota Department of Education	Children and Families 986 Capitol Square - 550 Cedar St. Paul, MN 55101-2273	EARLY CHILDHOOD SCREENING REPORT OF POTENTIAL PROBLEMS, REFERRALS, RESULTS	ED-01801-04 DUE: Aug. 15

GENERAL INFORMATION AND INSTRUCTIONS: This report is a tool for local and state evaluation of the Early Childhood Screening (ECS) Program. It corresponds to the Planning, Evaluation and Reporting (PER) process described in the ECS handbook. The following information on potential problems, referrals, and results will be incorporated into reports to the Legislature and other decisionmakers. Complete this report and submit it with the ECS Completion Report and Request for Reimbursement (ED-01611) at the completion of your program but **no later than August 15, 1995**.

IDENTIFICATION INFORMATION			
District Name	District Number	County Name	Date Report Submitted: _____
Name of Early Childhood Screening Coordinator	Telephone Number ( ) -	FAX Number ( ) -	☐ Preliminary ☐ Complete

SCREENING AND FOLLOW-UP

For each component, provide the numbers requested for each column in the "Screening and Referrral" and "Follow-Up" categories listed below. Since some children have more than one problem, the total Potential Problems may be greater than the number of children screened.

COMPONENT		SCREENING AND REFERRAL				FOLLOW - UP					
		TOTAL CHILDREN SCREENED BY COMPONENT	POTENTIAL PROBLEMS: PREVIOUSLY KNOWN	POTENTIAL PROBLEMS: NEW	REFERRALS MADE	REFERRALS FOUND TO BE NORMAL	PROBLEMS CONFIRMED	RESOLVED BY MEDICAL INTERVENTION	PLACED IN SPECIAL EDUCATION	PROBLEMS RESOLVED BY OTHER METHODS*	REFERRALS STILL INCOMPLETE
Vision											
Hearing											
DEVELOPMENTAL	Speech/Language										
	Cognitive										
	Fine/Gross Motor										
	Social/Emotional/Behavioral										
Growth - Height and Weight											
Immunization Review											
Health Care/Coverage Lack of Access										**	
Health Concerns (as learning risks)											
Other (Specify):											
TOTALS											

* Other Methods: Different education settings, ECFE, etc.
** Health Care Coverage Obtained

Total number of children with identified problems (new and previously known): _____ Number of children with multiple problems: _____

Please state your rationale for adding optional ECS components (e.g., Health History Review, Nutrition Review, Family Factors, Physical Assessment, Lab Tests, etc.):

2	REFERRALS DUE TO RISK FACTORS THAT INFLUENCE LEARNING

Provide the number of referrals made due to risk factors (by level of risk) that influence learning.

RISK FACTORS	LEVEL OF RISK	LEARNING READINESS		PARENTING CLASSES		HEAD START	ADULT EDUCATION/ LITERACY	ADDITIONAL FAMILY SUPPORT	OTHER PROGRAMS	REFERRALS INCOMPLETE
		REFERRED	PARTICIPATING	ECFE	OTHER					
EARLY CHILDHOOD EXPERIENCES	LOW									
	MODERATE									
	HIGH									
FAMILY SITUATION INFLUENCES	LOW									
	MODERATE									
	HIGH									
Other (specify):	LOW									
	MODERATE									
	HIGH									
Other (specify):	LOW									
	MODERATE									
	HIGH									

SCREENING PROGRAM COMPONENTS EVALUATION INFORMATION

OUTREACH: Check outreach methods used and rate the effectiveness of each:

	EXTREMELY EFFECTIVE	VERY EFFECTIVE	SOMEWHAT EFFECTIVE	NOT EFFECTIVE
☐ Direct invitation by census tract	☐	☐	☐	☐
☐ Radio and TV advertising	☐	☐	☐	☐
☐ Flyer(s) sent home with school-age children	☐	☐	☐	☐
☐ Local newspaper advertisement/article	☐	☐	☐	☐
☐ Other (specify): _____	☐	☐	☐	☐

If participation in screening changed over last year, check the reason(s):

☐ Change in population ☐ Improved Outreach ☐ Collaboration with other early childhood programs

☐ Other (specify): _____

SCREENING AND FOLLOW-UP: (See PER tool in the Handbook for ECS: Administration & Concepts)

A. Briefly describe the tools/methods used for identification of risk factors that may influence learning:

B. Having reviewed the screening and follow-up activities, check the activities below which require change:

☐ 1. Registration ☐ 2. Components: Procedures, Staff ☐ 3. Parental Guidance / Health Promotion ☐ 4. Clinic Management

☐ 5. Follow-Up: Confirming Findings ☐ 6. Follow-Up: Documenting Findings ☐ 7. Linkages With Other Early Childhood Programs

C. For each activity checked in item "B" above, (by number) briefly describe your proposed plans:

OUTCOMES: Describe, in general, the outcomes of ECS (if necessary, continue on the reverse side of this page using the item numbers below)

1. List specific cases with unusual findings:

2. Describe the health and development needs of children in your district as shown by this year's screening, and how they compare with results of previous years:

3. Describe how links to Learning Readiness and ECFE impacted children and families:

4. Based on ECS informaiton, indicate new health-related programs that are being considered or planned:

5. Based on ECS information, indicate new educational programs that are being considered or planned:

6. Other outcomes of ECS:

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4	SCREENING PROGRAM COMPONENTS EVALUATION INFORMATION (Continued)

ECS PROGRAM SUMMARY:

List the strengths of your district's ECS program:

List the weaknesses of your district's ECS program:

Describe the collaborative efforts with other programs or agencies:

List recommendations to the Minnesota Department of Education and the Minnesota Department of Health, including suggestions for inservice, materials, etc.:

Provide your screening dates as planned for the coming year: _____

Use this space for additional "OUTCOMES" narrative from page 3. Please reference each statement to the item number given on page 3.

INSTRUCTIONS FOR COMPLETING
ECS REPORT OF POTENTIAL PROBLEMS, REFERRALS, RESULTS

The data on this form is requested to illustrate how ECS is contributing to the National Education Goal.

Goal 1:By the year 2000, all children in America will start school ready to learn.

Objectives:

- All disadvantaged and disabled children will have access to high quality and developmentally appropriate preschool programs that help prepare children for school.
- Every parent in America will be a child's first teacher and devote time each day helping his or her preschool child learn; parents will have access to the training support they need.
- Children will receive the nutrition and health care needed to arrive at school with healthy minds and bodies, and the number of low birth weight babies will be significantly reduced through enhanced prenatal health systems.

ECS addresses all three of these objectives. Progress toward this goal can be documented by collecting information on potential problems, referrals and results. A specific example of how this information can be helpful is the perception that behavioral concerns among young children are increasing. The number of behavioral concerns identified, the referrals made and the interventions provided (ie. ECFE, Learning Readiness, medical evaluation, other family support such as counseling, Special Education services or Child Protection services) are important information for evaluating this perception. Future health, educational and social service programs can be planned.

Input from an advisory group of ECS coordinators and a school administrator was considered in revising this form. Suggestions for changes to this form that would increase the accuracy and relevancy of reporting or the ease of completing the form are welcomed.

PRINCIPLES

- The findings in this report serve to illustrate the needs of children that ECS identifies and the outcomes for children that ECS facilitates.
- The numbers in this report will indicate the links to other early childhood programs such as Learning Readiness, Early Childhood Family Education and Head Start that ECS provides for children.
- This report will quantify risk factors that influence learning and may be used to develop additional policies and programs to serve preschool children.

DETAILS

Due date is August 15.

Identification Information

Please be sure to note the current ECS Coordinator and school district address.

Screening and Followup

1. List the number of children screened by component. These numbers should match the number screened by component on the ECS Completion Report and Request for Reimbursement (ED-01611-xx).
2. List the number of previously known conditions. For example, the child wears glasses and is under regular care of a health care provider who has diagnosed amblyopia or the child has had behavioral concerns, is seeing a therapist and has been started on a trial of medication. Some of these children may have lapsed from care, so should be included here, but also included in referrals made (see #4).
3. List the new findings identified at ECS. For example, the number of children referred for immunizations, the

number of children identified with speech concerns, the number of children noted to have significant behavioral concerns, or number of children small for age.

4. List the number of referrals made for each component. This includes children who have known problems that need further attention (see #2) and new problems (see #3). Sometimes new problems are not referred, such as the child small in stature according to the growth chart, but whose parents are small in stature also.

5. List the number of problems confirmed (true positives). This represents the number of children identified with an educational need after assessment for special education or who obtain a diagnosis of a medical condition. Some potential problems noted at screening may not be found to be confirmed problems (false positives).

6. Indicate the number of confirmed problems that are resolved by medical intervention. For example, a child has hearing loss associated with a history of ear infections. Following medical treatment such as PE tubes the hearing is normal and the condition is resolved. Or the child is observed to be and reported by the parent to be impulsive and inattentive; following medical evaluation a diagnosis of ADHD is given and treatment with medication resolves the behavioral concerns.

7. List the numbers of children placed in Special Education following a formal assessment.

8. List problems solved by other methods. This can include a range of resources, for instance ECFE for mild delays in development such as inexperience with fine motor activities or lack of social interaction skills. It could include services such as private speech therapy if a parent chooses this option.

9. Indicate the referrals that are still incomplete. This may be due to many factors such as the child is still being evaluated at the time the report is completed, the child is under observation by a health care provider for the condition, the parent has not been able to complete the referral. If the latter is the case, the standards for followup indicate at least two attempts be made to contact the parent, one of which is by mail with return postage. Parents may need additional explanations of the findings or assistance in locating resources.

10. Complete the numbers for each of the components listed. Please note that health conditions are listed on this page with the required components because the identification of potential problems and confirming of potential problems fit into this format. Health concerns (as learning risks) identified at ECS might include a wide variety of signs and symptoms reported by the parent or observed by the staff. For instance a parent might report a concern about staring spells on the health history. Staff might also observe this behavior. Further questioning by a health professional about the condition might indicate the need for referral to a health care provider for evaluation for seizures. Possibly staff might observe a weakness of one side of a child's body during fine and gross motor activities indicating a need for a health care provider to assess the child. Findings and referrals for such conditions should be noted.

11. Indicate the number of children who do not have health care under "Lack of access to health care/coverage." Indicate the number who have received health coverage.

12. Total each column.

13. Please identify the total number of children with identified problems (new and previously known). Some children have more than one problem, so this total count of **children** may be less than the sum of the two columns above (previously known and new). Then indicate the number of children with multiple problems.

14. If you list optional components in the one of the rows titled "other", please specify the component.

Referrals due to Risk Factors that Influence Learning

1. Indicate the number of children in each category: low, moderate, high. Children at **low risk** have families with multiple strengths and resources. Referrals are for the purpose of enhancement. **Moderate risk** indicates a delicate balance of demands and resources. Referrals are indicated for prevention and to increase coping skills and bolster resources. Children in the **high risk** category have families that are experiencing many more demands than resources; referrals are made for intervention and support.

2. Indicate the number of referrals to Learning Readiness.

3. List the number of children actually participating in Learning Readiness as a result of ECS referral.

4. Indicate referrals to Parenting classes, ECFE and Head Start.

5. List the number of parents referred to Adult Education literacy classes.

6. Indicate the number of referrals to additional family support services. This includes resources for chemical dependency and mental health. It also includes referrals to behavioral management programs, to public health and to child protection. Other referral sources for family support that are available locally should be included here.

7. Indicate these referrals under the appropriate identified concern: need for early childhood experiences, identified family situation influences or other (please specify).

Evaluation Information

Outreach: Indicate which outreach methods were used and rate how effective the method was. Please describe.

Screening and Followup:

1. Identification of Risk Factors that Influence Learning is a required component. The determination of what to include in this component is made locally and typically includes early childhood experiences, family needs and resources, health history and health care resources. Please describe what you have determined to be the risk factors that make up this component. Include the tools you use (health history, family factors interview, other).

2. Check the areas of the ECS program that need change. Review the program and determine which components or aspects need evaluation, improved practice or for which staff need additional training.

3. Describe plan to meet the needs indicated above.

Outcome:

1. Describe in general ECS outcomes.

2. List specific cases. Anecdotal reports are helpful in describing the purpose and merits of the ECS program.

3. Indicate how the needs of the children compare to other years. Are there increased concerns about behavioral issues? Increase or decrease in need for referrals for routine health care and immunizations? Are families connected to programs such as ECFE and Head Start before they attend ECS?

4. Describe any new health or educational program being planned as a result of ECS findings.

Program Summary

1. Describe the strengths and weaknesses of your ECS program. Do families spend too much time waiting? Is the followup process in place? Does outreach need to be improved? Are you reaching the targeted age of 3½ to 4? Are resources available to meet the identified needs?

2. Please describe collaborative efforts you have developed to conduct ECS, to assist with outreach or to improve followup. What links have you established to improve referrals and services for children and families?

3. Make recommendations to Minnesota Department of Education and the Minnesota Department of Health for inservice and training, materials or other suggestions.

4. Provide screening dates as planned for the coming year. Make a copy!! Send it in!! MDE/ECS/rel/3/95

CONTACTS FOR
MINNESOTA EARLY CHILDHOOD SCREENING
MARCH 1995

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Minnesota Department of Education
Capitol Square Building-550 Cedar Street
St. Paul, MN 55101

Office of Service Design and Collaboration

Children and Families Initiatives

Lois Engstrom, Team Leader, Community and Family Education	612/297-2441
Debbykay Peterson, Program Specialist, Early Childhood Screening/Learning Readiness	612/296-1398
Betty Cooke, Program Specialist, Early Childhood Family Education	612/296-6130
Jan Rubenstein, Early Intervention Coordinating Council (Part H)	612/296-7032
Robyn Widley, Program Specialist, Early Childhood Special Education	612/296-5007
Michael Eastman, Early Childhood Procedural Safeguard Specialist	612/297-3056

Regional Interagency System Change (RISC) Contacts

Kay Campbell, Regions 1 & 2	218/681-8005
Marilyn Nelson, Region 3	218/723-4150 x220
Loraine Jensen, Region 4	218/739-3273
Sara Schoepf, Region 5	218/894-1930
Peggy Imholte, Region 7	612/255-4862
Pat Lytwyn, Region 6 & 8	507/537-1481
Becky Byrn Petzel, Region 9	507/389-1882
Sandy Grave, Region 10	612/385-5969
Judy Wolff, Region 11	612/490-0058 x112

Office of Finance Reform and Accountability

Education Funding Team

Greg Sogaard - Payment for ECS	612/296-8130

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Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155

Health Care Management Division

Mary Bruns, Child & Teen Checkups Coordinator (formerly EPSDT) & MA/MCH-Fiscal Policy	612/296-6040

MinnesotaCare Division

MinnesotaCare - Applications and Information	800/627-3672 or 612/297-3862
Sue Benolken, Early Intervention Coordinating Council	612/297-5979
Karen Carlson, Supervisor, Family and Children's Service Division	612/297-3381
Barbara O'Sullivan, Social Service Program Consultant	612/296-8540

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Minnesota Department of Economic Security
390 N. Robert Street
St. Paul, MN 55101

Economic Opportunity Office: Head Start Contacts

Sharon Shapiro, Specialist, Head Start	612/297-2206
Joelle Hoeft, Specialist of Head Start	612/296-5443

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Minnesota Department of Health
717 Delaware St. S.E./P.O. Box 9441
Minneapolis, MN 55440-9441

Screening Program Contacts

Jean Cronje, Supervisor, Child Health Screening/Health Promotion	612/623-5542
Roger Pacquin, Supervisor, Hearing & Vision	612/623-5288
Don Ogston, Consultant, Hearing & Vision, Duluth Contact	218/723-4645
Jan Stenger, Consultant, Hearing & Vision, Fergus Falls Contact	218/739-7585
Kate Kalb, Adolescent Specialist	612/623-5107
Margaret Wise, Nursing Consultant, Infant and Child	612/623-5286
Maria Rubin, Nursing Consultant, Child and Youth	612/623-5342
Julie Kamrath, Secretary, Health Screening/Promotion	612/623-5528
Marie Scheer, Children's Mental Health Consultant	612/623-5328

Other Key MDH Contacts

Diane Jordan, Librarian	612/623-5092
Laurel Briske, Injury Prevention Nurse Consultant	612/623-5202
Fran Doring, Consultant, Nutrition	612/623-5279
Cheryl Norton, Immunization Unit	612/623-5568
Mildred Roesch, Public Health Dental Hygienist	612/623-5529
Cheryl Smoot, School Health/Child Care	612/623-5291
Jan Jernell, MN Children with Special Health Care Needs, Section Chief	612/623-5150
Kim Miner, FAS Prevention Program	612/623-5334
Hannah Cooper, FAS Prevention Program	612/623-5276
Doreen Johnson Kloehn, FAS Prevention Program	612/623-5338

District Nursing Consultants - (PHN's)

Mary Rippke, Public Health Nursing Director	612/296-9798
Nancy Kern, Field Services Supervisor	612/296-9133
Marie Margitan, Northeastern District	218/723-4642
Sue Strohschein, Public Health Evaluation	612/296-9581
Linda Olson-Keller, Metropolitan Area	612/296-9176
Terre St. Onge, Northwestern District	218/755-3820
Dorothea Tesch, South Central District, South Central District	507-389-2501
Karen Zilliox, West Central District	218/739-7585
Joan Lee, Southeastern District	507/285-7289

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EARLY CHILDHOOD SCREENING
Statewide Summary
Report of 1992-1993 ECS Completion Report and Request for Reimbursement

Information and data for this report are obtained from reports submitted by individual districts. It may be helpful in comparing individual district cost figures to the statewide average costs to remember that these numbers are averages. Some questions to consider while reading this report include: are the participation rates in a district comparable to the statewide rates and ages? Is the number of children screened by other sources increasing? How does the local cost for screening compare to the state average for the total screening as well as for the individual components? Is the cost of optional components low enough to consider adding them to the screening?

GENERAL INFORMATION

1. Number of children eligible for 1992-1993 program:
(This number is a total of the local district estimate of a single age cohort)

59345

2. Number of children screened prior to kindergarten "catch-up" program:

		% of total
age 2	652	1.0%
age 3	11280	17.6%
age 4	36408	56.8%
age 5	12491	21.0%

3. Number of children screened in a kindergarten "catch-up" program

5594 8.7%

4. Total number screened: 63433

5. Number of entering kindergartners screened by other sources:

Private health care provider	306	.5%
Public health agency	527	.8%
Headstart	1023	1.6%
Other	758	1.3%

6. Total kindergartners screened by other sources than local district:

1694 4.2%

Comment: Over 70% of children are screened at ages 3 and 4. This is an encouraging indication that districts are focusing ECS outreach efforts at the targeted age of 3½ to 4. These numbers indicate that ECS is reaching over 90% of Minnesota children prior to kindergarten entrance. The large urban and suburban districts have the highest numbers of children not screened prior to kindergarten. High rates of family mobility contribute to the difficulty reaching some children. Increased awareness of the ECS mandate by parents and community members, and increased links with other preschool programs are expected to impact this number. It will be interesting to evaluate this number in the future as well as continue to look at successful means of reaching all children. The number of children screened by other sources is about 4%. Districts can be encouraged to expect some children to receive a comparable screening elsewhere. It is anticipated that this number will rise as local health care providers become more familiar with the ECS mandate.

AVERAGE COST OF ECS: (Includes outreach, screening and follow-up. Includes administration, rent and materials and training and supervision of staff for required components):

$39.66

District size does affect the average cost. The cost for screening increases as the school district size decreases.

	Average Cost	**%of districts**
Urban	$38.37*	< 1%
Suburban	$38.70	14%
>250 children (kindergarten age)	$39.25	13%
100 - 250 children	$43.91	20%
50 - 100 children	$43.47	32%
< 50 children	$45.52	54%

* represents St. Paul and Duluth.

REQUIRED COMPONENTS:

Outreach: Costs total 5.3% of the total costs statewide. This amount varies significantly across districts and was not calculated (statewide) on a per pupil basis. A look at individual districts indicated that districts reported a cost ranging from $.50 to $6.00 per student for outreach efforts.

Screening component:	**Average Cost:**
vision/hearing	$ 3.02
development	$10.16
height/weight	$ 1.43

family factors	$3.74
immunization review	$2.06
summary review	$4.22

TOTAL for required components (does not include outreach, follow-up, administration or other costs such as supplies, rental etc.: **$24.50**

Follow-up:
16,902 children (26.3%) $9.31

Staff: Districts report a range of backgrounds of the personnel providing screening. Outreach is accomplished by ECS coordinators, Learning Readiness teachers, ECFE staff, school nurses, and ECSU staff. Often volunteers, paraprofessionals, and school secretaries are part of the outreach efforts. School nurses and public health nurses are most frequently used to provide professional supervision of vision, hearing, and growth components. They also frequently perform family factors, immunization review, summary interview,and are responsible for follow-up. Less frequently they perform developmental screening. Volunteers are most frequently trained to provide growth measurements but also screen vision and hearing in many districts. Developmental screening is often done by a professional with an educational background and this varies from district to district with many using a combination of ECFE and ECSE staff.

Family Factors is completed by both nursing personnel and by educators, primarily ECFE parent educators. Summary interview is completed by school nurses, public health nurses, ECFE staff, and by special education staff (often from the ECSU). Less frequently districts use other personnel to assist with screening including speech clinicians, school psychologists, elementary counselors, kindergarten teachers, school social workers and trained paraprofessionals. Volunteers are used frequently in the vision and hearing components and in growth measurement. They are also used in outreach efforts and in welcoming families. Districts do report the use of volunteers with professional skills however this is infrequent. Follow-up activities are often reported as the responsibility of the ECS Coordinator. School nurses, special education and Learning readiness staff are commonly involved in all or portions of follow-up.

Funding: 1992-1993 State Aid Entitlement is $25.00 per child screened. Supplemental funding to cover the portion of screening costs not reimbursed by the state aid allotment is determined locally and comes from a variety of resources. General fund revenues and Learning Readiness resources are the most common source of additional funding. School districts also use ECFE, Special Education and Community Education funding. Local service agencies are reported as a source of funding as well as voluntary services. In-kind services are cited by many districts and include space, informational brochures as well as services such as a dietician or dental hygienist, physician or other health care provider and public health nurses.

Comment: Vision/hearing costs ranged from $0.75 to $16.00. This extreme difference can, in part, be explained by the use of volunteers vs. professional screeners. However the figure of $16.00 for a procedure that should on average take less than 20 minutes seems extreme. It should

be noted that this figure ($16.00) was reported by 7 districts. Development costs ranged from $2.96 to $51.82. Both of these figures seem unrealistic - this component requires 1:1 administration of a standardized tool that in general should take 15-20 minutes to administer. However the average cost of $10.16 seems realistic. In general the districts that had higher costs for development tended to be using the DIAL-R instrument for screening. Height/weight costs often were reported as less than $1.00 which seems realistic given the frequent use of volunteers for this component. A few programs reported quite high costs such as $10.00 and $20.00. Perhaps this includes PHN time that should be attributed to nutrition assessment or to health history.

Family Factors costs varied from $1.35 to $17.59. The average cost of $3.74 seems somewhat low. The explanation may be that if the parent completed the Family Factors form prior to screening (as was suggested) a short interview was all that was needed in many cases. Possibly districts found this figure more difficult to quantify and therefore report. Also perhaps when the component is done in conjunction with a health history and nutrition assessment as well as immunization review and summary interview the cost is less and therefore the average appears low. Done in this manner the average cost for the combination of components would be $14.88 which might be realistic for a twenty minute interview with a parent. In my experience if the parent brings completed forms a combined interview can realistically be done in twenty minutes (average). An additional factor would be the commitment of the individual ECS program to the component and the degree to which the program has decided to invest time and resources. Immunization review costs were reported from less than $1.00 to a high of $26.00. The average of $2.06 seems realistic. Summary interview costs were reported as low as $1.35 and as high as $28.00. Again neither of these figures appear realistic. The average reported figure of $4.22 does seem somewhat low and perhaps the same explanations as above (Family Factors) are true here also. Additionally, if all the other components are done separately (ie. at a different station) and the summary form is well completed at each station then this may be accurate for an estimated summary interview time of 10 minutes which is probably a realistic average time.

OPTIONAL COMPONENTS:

screening component:	**% of children (statewide) completing component**	**average cost**
health history	58.0%	$2.33
physical inspection	3.5%	$11.92
lab tests	1.9%	$7.87
dental	10.3%	$1.22
nutrition	25.2%	$2.53

Total of average costs of optional components: **$25.87**

Comment: Districts offer a range of none to all of the optional components. Health History costs ranged from $0.71 to $6.11 which may reflect some of the same issues as discussed in Family Factors above. A significant number (58%) of children continue to participate in the health history component. This is usually offered by the school nurse or county public health nurse often in conjunction with the summary interview. Districts have found various ways to fund the optional components. Some districts choose to fund components they feel are valuable, others use in-kind services from local agencies such as dental or health care providers or public health agencies. Some request a donation from families or charge a nominal fee ($5.00).

Parent response: ECS is required prior to kindergarten. Many districts added late spring, summer and early fall screening clinics in order to screen children who had been missed previously or had recently moved into the district. Districts reported that many parents were comfortable with this requirement. ECS Coordinators expected that less than 5% of families would request the exemption (an option in the 1993-1994 school year).

Comments from parents:

"it was great to be told she was doing well and to see her independence"
"I have very shy children and having people take the time was great"
"I received a great deal of information while I was here"
"it was good to have her hearing and vision checked"
"lets you know what areas to work on"
"everything was explained very well"
"a lot of waiting"
"well worth the two hours spent"
"they make you aware of resources where there is a need"
"it is somewhat intrusive - but we understand the state mandate"
"I feel more comfortable knowing how my child is developing mentally and physically - so I am more aware of how to help him"
"if there was a problem it could be found and the child could get help before entering school"

July, 1994
Ann Hoxie
ECS Specialist
Minnesota Department of Education